State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey 1999 **Physician** 24, 1:40am VIOLA FOWLER April /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4e. Fecility Name (If not Institution, giva street end number) Examiner Suburban Hospital Bethesda Montgomery if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** 1□M XXF Yrs. 578-54-1908 Director June 9, 1921 Virginia Usuel Residence of Dacedant with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Md. Prince Georges Clinton 1 XYes 2 No Director 10f. Zip Coda 10g. Citizen of Whet Country? 10e. Street end Number 20735 3503 Manis Road US.A. death Funeral 14. Race - Amarican Indian. 12. Was Dacedanf Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status Bleck, White, afc. filed within 72 hours after Hygiane. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 ☐ Never Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: Black by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th Housekeeper Private other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) permit. Pegas 1 and 2 should be filk Department of Haalth end Mantal Hy Important: If item 27 Is marked oth any linjury or other traumatic event soigs. Andrew Jackson Willie Wren 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 3503 Manis Rd, Clinton, Md. 20735 James H. Fowler/Son 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Family Cemetery 5/1/99 Palmyra, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Johnson & Jenkins Inc. 21. Signeture of Funeral Service Licensee 716 Kennedy St., N.W. Washington, D.C. 20011 23a. Párt1. Enter the diseese, or cour shock, or haert feilure. List only Approximete Intervel Batween Onset end Death is that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, PLysician Immadiete Ceuse (Final disease or condition resulting In deeth) Medicai AIGOOUSTA Examiner Due to (or es e consequence of): Examiner JAPSIS that the death certificate be executed the attanding physician end hed for usa es tha buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of). DIABRIBS Physician/Medical Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown been signed by þ towler, Viola 8 24b. Were eutopsy findings aveileble prior to 24a. Was an autopsy performed? Completed completion of causa of deeth? After this certificate has 1□Yes 21 No 100 Yes 2 No Division of Vital Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □ Other (Specify) 2 1 Yes 2 KNo 1 Dinpatient 2 □ ER/Outpatient 3 □ DOA funerai 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 [] No To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A investigation death. the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office sidiling, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 C Homicid on the best of m showledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Initiation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29s. Certifier Certifying Physici Medical complately manner stat 29d, Date signed (Month, Day, Year) 29c. License number 29b, Signatu H0051280 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) ANUSHIRAVAN DADCAAR, DO 13219 BYRCUTUR MRK TRARACE, CARRIND DOON NO 20874

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 8 1999

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner

Funeral Director 10a. State ns 23e or 28e-f show must be notified at Director Funeral the Medical Examiner b þ Completed and Mental I Be Pages 1 and 2 should be RALPH if of Health if Item 27 h Important: if its any inju-**Physician** /Medical Examiner Examiner The law requires that the death certificate be executed Box 68760, physician Physician/Medicai the signed by the e P.O. Records, þ Completed certificate Division of Vital Attending Physician: funeral director. Be Certification: To 1 | Yes this After re Hospital or Attending in 24 hours effer death. the Funeral Director: Aft 1 Naturai 2 Accident 3 Suicide Medical 29e. Certifier completely (Check only one) To the I

1. Decedent's Neme (First, Middle, Last) 3. Time of Death 8:35Am ROSA KAYE FOREHAND 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE DOCTORS COMMUNITY HOSPITAL LANHAM Hours Min. SEPT . 14, 1950 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthpiace (State or Foreign 1 □ M 2 1 F Months Days BUFFALO. NY Yrs. 078-40-9349 10b. County 10c. City. Town or Location 10d. Inside City Limits PRINCE GEORGE LANHAM Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8606 SAFFRON DRIVE 20706 U. S. A. 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) + YEARS CONSUMER SAFTY OFFICER FOOD & DRUG ADMIN. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DURANT ROSA MURCHISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE D. FOREHAND-DAUGHTER 4741 RUSSWOOD AVE. STONE MOUNTAIN, GA 30083 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) QUANTICO NATIONAL CEMETERY QUANTICO. VA 21. Signature of Funeral Service Licens PINCKNEY-SPANGLER FUNERAL HOME eleramo 524 - 8TH ST., N. E. WASH., D. C. 20002 the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, and indicate. List only one cause on each line. Approximate interval Between Onset end Death Immediete Cause (Finel disease or condition resulting in death) Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings avellable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: No No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed cause of death (item 23e) (Type, Print) 1EHR 10600 RIVER OAKS LANE POTOMAC, MD

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 7 1999

32. Registrar's Signeture

APP 2 V 1 m

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Deta of Deeth 3. Time of Deeth Physician 1955 1245 4b. City, Town, or Location of Deeth Leanna Fountain /Medicai 4c. County of Death WICOMICO 4e. Facility Neme (If not institution, give street end number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Undar 1 Yaar Months Deys If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplece (Si Country), Mar. 11 1918 Georgia Birthplece (State or Foreign Country) **Funeral** 1 M 2 M F 124-16-1212 Director Usual Residence of Decadent worle 10b. County 10c. City. Town or Location 10d. fnside City Limits r than "natural", or items 23a or 28a-f ehor the Medical Examiner must be notified at 1 ☐ Yas 2 No Funeral Director Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? P.O.Box 838 21826 U.S.A 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detas: 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Raca - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry important: If item 27 is marked other than any injury or other traumatic event, Ita Mar once. Eiementery/Secondary (0-12) Cotiege (1-4or 5+) Domestic None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be lant of Health and Mental Unknown 2 Unknown 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 104 Coulbourne Mill Rd.Salisbury, Md. 21 804 Elton Fountain (Husband) 20b. Place of Disposition (Name of cametery, cremetory or other place) 4/29 20e. Method of Disposition 20c. Location - City or Town, Stete Burlel 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) Cottage Grove Westover, Md. 21 Signature of Funeral Service Licenses Stewart Funeral Home B, West Rd.Salisbury, Md. 21801 23e. Pert 1. Enter tha disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or hear feiture. List only one cause on each line. Approximete Intervei Between Onset end Deeth Physician Immediate Cause (Finet disease or condition resulting in death) /Medical IWK. PNEUMOSTIA. Examiner Due to (or es e consequence of) Examiner attending physician and for use es the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): signed by the at d be datached fo Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobecco use contribute to the cause of deeth? Yee 2 No 3 Probably 4 Unknown ASCUB þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed Day 7/A PUIS 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, t 25. Wes case referred to medicat exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ■ No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stete) Pieca of injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide edicai Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the besis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, data and place, end due to the cause(s) end menner steted. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 32014 Many 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 106 WIFORD ST SWE SOYB SALISBYRY MD 21804

State Registrar

31. Dete fited (Month, Day, Year) APR 2 7 1999

MAHEGH MOONDRA

32. Registrer's Signeture Genera

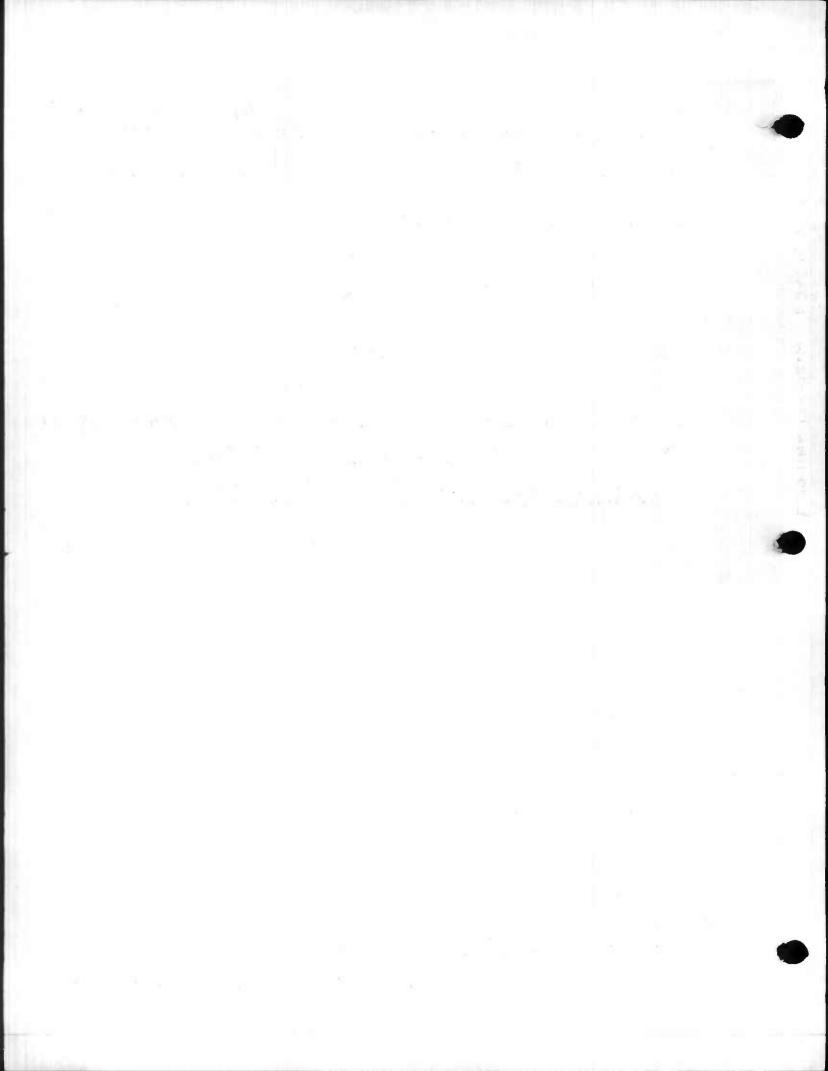
that the death certificate be axecuted

P.O. Box 68760,

Records,

Division of Vital

eanna Fortlain



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 26, 1999 arth 4c. County of Deeth April 8:45 AM LARRIMORE FRANKS 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southhampton Bridge Rd. Salisbury Wicomico If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 □ F Days Hours Min 220-28-1440 Yrs. 65 December 20,1933 Maryland Usual Residence of Deceden 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30435 Southhampton Bridge Rd. 21804 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: Army 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Sacondary (0-12) Coilage (1-4or 5+) Office Equipment Salesman 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Larrabee Franks Genevieve Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta A. Franks/Wife 30435 Southhampton Bridge Rd., Salisbury, MD 21804 20b. Ptace of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cramation 3 Removal from State 4/28/99 Parsonsburg, MD Jerusalem Cemetery 4 Donetic 22. Name end Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 enter the mode of dying, such as cardiac or respiretory errest. Approximate Intarval Batween Onset and Death Immediate Cause (Final ane Smos, disease or condition resulting In death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consaquance of): Due to (or es a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 20 No 3 Probably 4 Unknown 1 Yas 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy 28 No 1 Yes 2 No. 1 Yes 25. Was casa raterrad to madical 26. Place of Daath (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA 27 Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Naturat 2 Accident 5 Pending investigation 1 Yas 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rurel Route Number, City or Town, State)

law requires that the death certificate be asscuted attanding physiclan a for use as the burial-Division of Vital Records, P.O. Box 68760, signed by the all should b is certificate had The Hospital or Attending Physician: 24 hours after death. this funeral After Director: / To the Hospital or within 24 hours aff To the Funeral DI completaly filled in

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: If them 27 is merked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Modical Examiner must be any observed.

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

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2

Certification:

Medical

4 Homicide

(Check only one)

Signature and title of certific

29a, Cartifian

Baltimore, Maryland 21215-0020

104114

State Registrar

Core 31. Date filed /M

30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print) 145€. Cowell

28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

Solish, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states.

29c. License number

29d. Dete signed (Month, Day, Year)

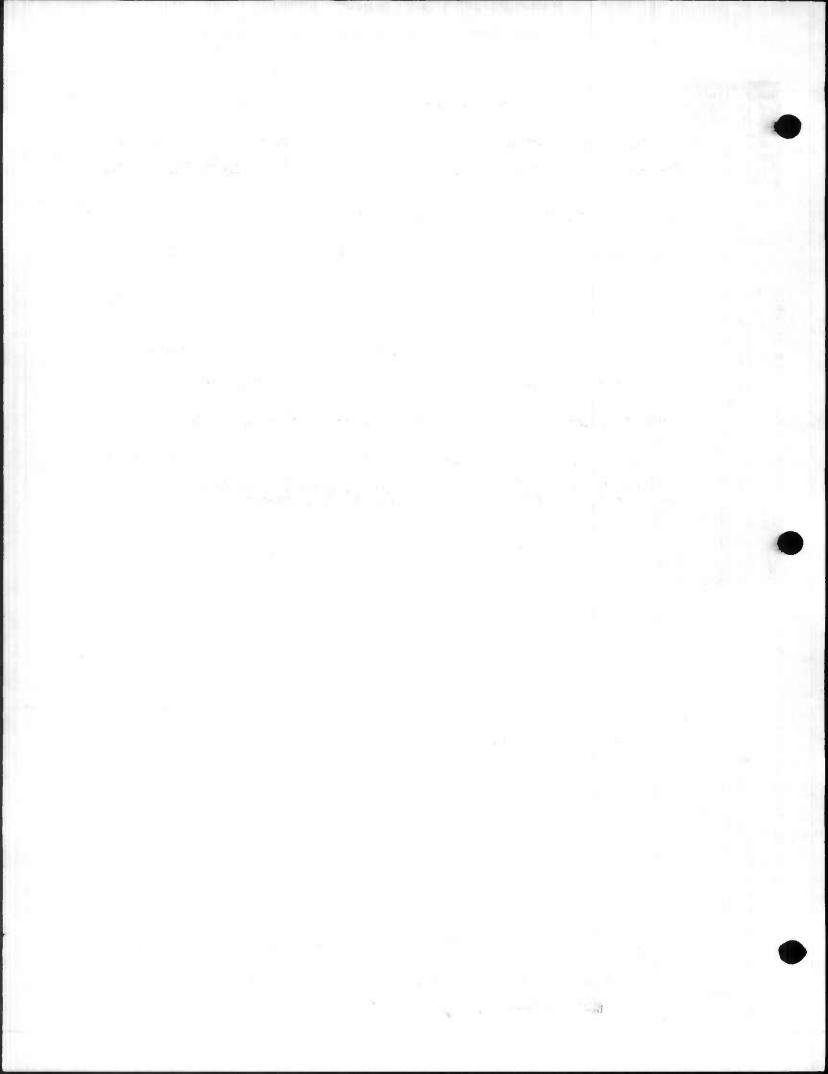
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First Middle Lest) 2. Data of Death 3 Time of Death **Physician** Ment 3, 1999 8 AM Mina Loretta Sweeney Foltz /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Undar 1 Yaar if Undar 24 Hrs. Birthplaca (State or Foreign Country)
 D 7. Aga (In yrs. last birthday) **Funeral** 1□ M 25 F Months Days Hours Mir 235-12-1007 86 Yrs Director Usual Rasidance of Dacadant the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Insida City Limits other treumstic event, the Medical Examiner must be notified at Frederick Middletown 1X Yas 2 No Director MD. 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò 21769 U.S.A. 104 Broad St. items 23a Funeral 12. Was Dacedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours aftar Hygiana. 1 ☐ Yas 2 🔯 No If Yas, Giva Yaar or Datas: 1 ☐ Navar Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mantal Hygians I important: if them 27 Is merked other than "natural", or I any Injury or other treumatic awart Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 15. Decedant's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Coltage (1-4or 5+) office clerk agribusiness 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Sumeme) Be Victor H. Sweeney Nora Otzelberger 19a. tnformant's Name/Relationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 8910 Gloria Ave., Middletown, MD. Kenneth Foltz (Son) 20b. Piece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Specify) 5/7 Middletown, MD. Lutheran Cemetery 22. Nama end Address of Facility

Donald B. Thompson Funeral Home 21. Signature of Funeral Se 31 E. Main St., Middletown, MD. Part. Enter tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximata Onsat and Death **Physician** /Medical TLUIN tmmediate Ceuse (Finel disaesa or condition rasulting in daath) **Examiner** Dua to (or as a consequence of) Examiner burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that Initiated events rasulting in daath) Last and Dua to (or as a consequence of): Box 68760. ettanding physiclan for usa as the buria Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tha 23b. Did tobacco use contribute to the cause of death? signed by t d be datach Ley Ly 1 □ Yes 2 No 3 Probably 4 ☐ Unknown Division of Vital Records, þ The law requires 24e. Was en eutopsy parformed? Completed 24b. Were eutopsy findings available prior to peeu complation of causa of daath? ata has t 1 Yas 2 No 1 Yas 2 No cartificata To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica complataly filled in by the funeral director; p Be 25. Wes cese rafarred to medical 26. Place of Death (Check only one) examinar? ၉ Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yaar) 27. Manney of Daath 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Daturel 5 Panding 2 Accident 1 ☐ Yas 2 ☐ No invastigation 6 Could not be data mined 3 Suicida 28f. Location (Straat and Numbar or Rurel Routa Number, City or Town, Stata) 28a. Place of injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.
2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) end mannar stated. 29a. Cartifier Medicai (Check only one) 29b. Signeture and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nema and address pf person who completed causa of daath (item 23e) (Type, Print) TOCILA 1410 310 -uven 140 OCH-07 Registra's Signature 31. Dete filed (Month, Day State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate	of Dea	th		Reg. No.	10	300
Physician		I. Decedent's Nama (First								2. Dete of E	Deeth // Dev	Yeer	3. Time of Death
/Medical		Bertha Vir	ginia	Virts F	armer					apri	L 29	1999	2115
Examiner		e Fecility Neme (If not in						1	, Town, or Loc			ty of Deeth	
		Washington							erstown			nington	
Funeral Director		Social Security Number 243–28–8463		x 2⊠ F	Age (In yrs. 83	last birthdey) Yrs.	Months D	Yeer If Un Deys Hou	oder 24 Hrs. Irs Min.	B. Dete of B (Month, L pril	Sirth Year)	9. Birthplac Country Hamilt	on VA
p	_	Jsuel Residence of Deced	County		10c, City	y, Town or Lo	cation					10d	. Inaide City Limits
with the Maryla a or 28a-f abov the notified at Director			shingt	on		pland							1 ☐ Yes 2 No
or 28s-f at he notified Director	-	171D W 0	Siringu	011	Ga	pranu	10f. Zip Co	nde			10a Citizen of	What Country	2
23a or nust be real Dir		3207 Gaplan						21736			USA		
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State Registrar

Dennis J.
31. Date filed (Month, Day, Year) MAY 0 3 1999

30. Name and address of person who co

32. Registrar's Signature

npleted cause of death (Item 23a) (Type, Print)

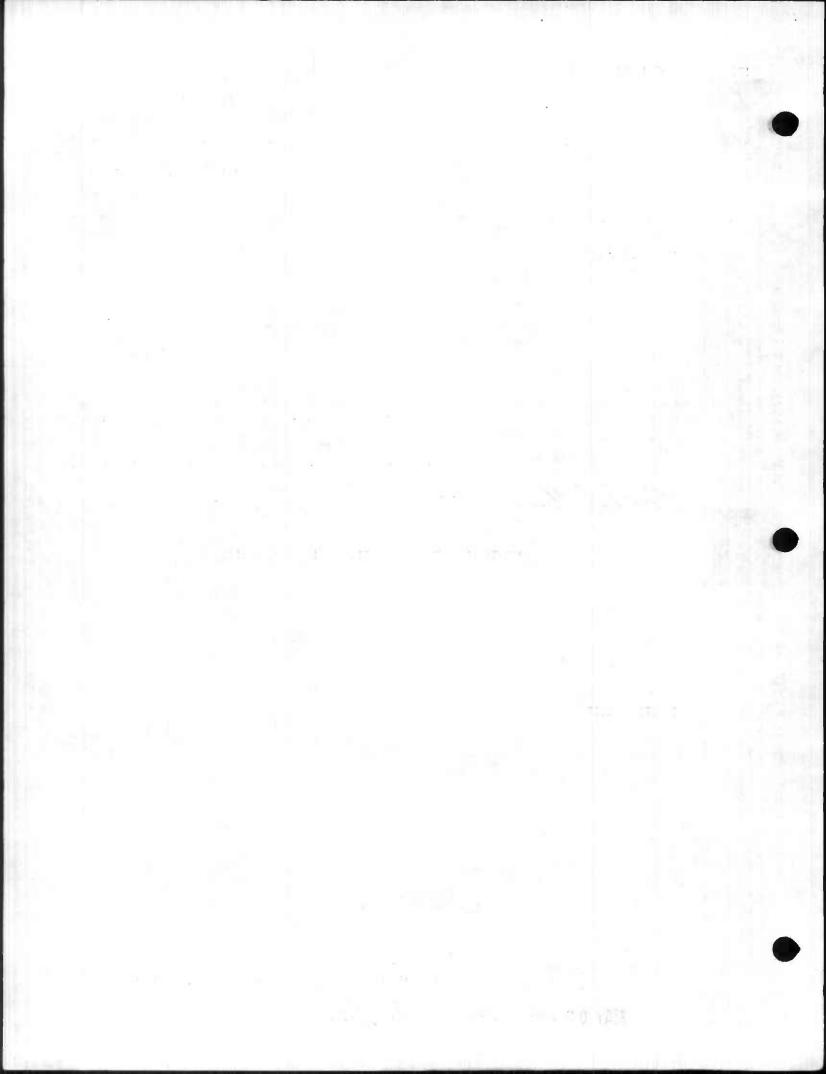
111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 29, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item #26, Per Phy. State of Maryland / Department of Health and Mental Hygiene 04/28/99, Carroll County, wjl Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** RICHARD SAMUEL GREENHOLTZ 24, APRIL 1999 2258 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 213-36-9164 60 Director MAY 1938 BALTIMORE Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Marylan Hygiene.
Whysiene "natural", or items 23a or 28a-f ahow and, the Medical Estim or mast be notified a sind, the Medical Estim or mast be notified as 10b. County NELYes 2□No Director CARROLL WESTMINSTER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 SHAFFER AVE. 21157 USA. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1 9 5 8 If Yes, Give Year or Dates: 1 9 6 8 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Nevar Married 2☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sign Painter 12 MANUFACTURING Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event page. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HARRY RICHARD GREENHOLTZ MARIE ELIZABETH BECKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORETTA SCHAEFFER - FRIEND 305 SHAFFER AVE., WESTMINSTER, MD. 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/99 NEW WINDSOR, MD. BETHANY CEMETERY 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part 1. Enter the disaase, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final min disaasa or conditior resulting In death) Examiner Physician/Medical Examiner sician and burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury physician s the buria Box 68760. that initieted events resulting in deeth) Last Due to (or as a consequence of): 98 for use as P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 22 No 3 Probably 4 Unknown ð Records. The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was cese referred medical examiner? Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 edical Certification: To 3 Thesidence - 8 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation EMatural death. t ☐ Yes 2 ☐ No 2 Accident efter death 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 \ Homicide the Hospital within 24 hours To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Montk, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Washington 32. Registrar's Signature Tener

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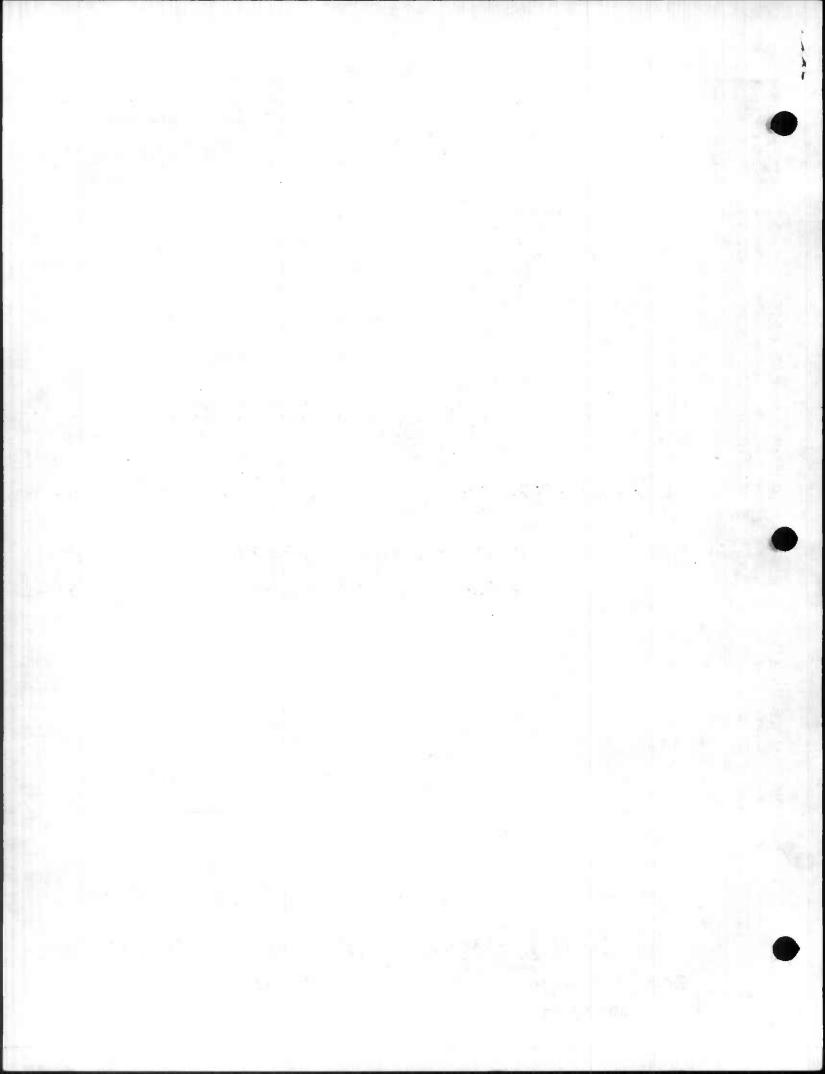
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Robert

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			State of Maryla	Certif	cate of	Death		Reg. No.) 5	5509
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pue Mc		10a. State 10b. County	10c. C	ity, Town or Location	n				10	d. Inside City Limits
Many First	to	Md. P.G.	Ca	apitol Hg	ts.					1 X] Yes 2 □ No
within 72 hours effer death with the Maryland ene. than "natural", or items 23a or 28a-f show its Med cal Examiner must be notified at	Funeral Director	10e. Street and Number 727 Mentor Av	enue	1	Of. Zip Code	43		10g. Citizen of U.S		у?
deed deed	ner	11. Meritel Status	12. Wes Decedent Ever in t Armed Forces?	J,S. 13. Was	Decedent of F	Hispenic Orlgin? (an, Mexican, Pue	Specity Yes or N	io- 14. Rec	ca - America	
d 2 should be filed within 72 hours efter th and Mental Hyglene. 7 Is marked other than "natural", or its traumatic event, the Medical Example.	b	1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorcad	1 Yes 2 No If Yes, Give Year or Detes:		res 2X No		no rican, etc.)	Specif	ck, White, et y: Bla	
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office of Hy	BeC	17. Father's Name (First, Middle, Last)		- A MARINETTE				e, Maiden Sumar	ne)	
Menta Menta arked	To E	Charles W. Neal,				Madal	ine C. 1	Brooks		
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or of the		20a. Method of Disposition 1 ⊠Buriel 2 ☐ Cremation 3 ☐ F		Placa of Disposition cemetery, cremeto			Data	20c. Location		
permit. Pages 1 ar Department of Hee Important: If item. any injury or other		4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Arlington	me end Addre		30/99	Ft. My	er, va	1.
Depermination of the second se		ary ary	N. Craz	# H.	S. Wash:	ington & roughs A	Sons Co	J.,Inc.	D C 2	20019
Physician /Medical Examiner		23a. Pert1. Enter the disease/or comp shock, or heart failura. List only o Immediate Cause (Final disease or condition rasulting in death)	ASYTOLE			ng, such as cardi	ac or respiratory	arrest,	1	Approximete Interval Between Onset and Death
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outed d ensit	Examiner	Sequentially list conditions	0,	or as a consequent	1					
te be executed ysician and te burial-trensit	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	24010	o, ac a cooq					1 1	
ifical as th	Physician/Medical	that initiated evants resulting in deeth) Last	Due to (or es e consequenc	a of):					
deeth cert e ettending ed for use	ian		J							
at the ded by the eletached	ysic	Part II. Other significant conditions co	ntributing to death but not re	sulting in the under	ying cause giv	van in Part I.	23b. Die	d tobacco use co		the cause of death?
requires that the sean signed by hould be detail	à						10	Yes 2 No	3 □ Probe	ably 4∭ Unknown
2 s ×	Completed							is an autopsy formed?	com	a autopsy findings lable prior to spletion of cause eath?
F # 8	Con						10	Yes 2 No	10	Yas 2□ No
ilcisn: The certificata rector, pag	Be	25. Was case referred to medical examiner?	lospital:		0	hor	eath (Check only			
Phys this	tion: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Netural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			sidenca 8 🗆 Otl		
al or Attending s after death. I Director: After id in by the fune	Certification:	3 Sulcide 6 Could not be datarmined	28e. Place of Injury - At 1 building, etc. (Special	nome, farm, street, ify)				(Street and Num. own, State)	ber or Rural	Route Number,
To the Hospital of within 24 hours at To the Funers! Do completely filled I	edicai (29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my known or the basis of examination and manner stated.	owledge, death occ atlon and/or investi	urred at tha ti gation, In my c	ma, data and piac opinion, death occ	ea, and due to the curred at the time	e cause(s) and m e, date and place,	annar as sta and due to t	ited. tha cause(s)
Vithi Vithi To th	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signe	ed (Month, D	lay, Year)
			- MD			01-056879		22 A		}
		30. Name and address of person who con E. A. ELSTER, LT,		m 23a) (Type, Print		TIONAL N THESDA N			ENTER	
	1	31. Date filed (Month, Day, Year)	2. Registrar's Sign							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral Director

permit. Peges 1 end 2 should be tiled within 72 hours efter death with the Maryland Depertment of Heelth end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

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THERESA 6051

Baltimore, Maryland 21215-0020

Physiclan /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after deeth.

To the Funeral Director, After this certificate has been signed by the ettending physician end completely filled in by the tuneral director, page 2 should be deteched for use as the burial-transi

			Ce	rtificat	e or	Death	7		Reg. I	No.		
1. Decedant's Name (First, Mid Terresa Lo		en				_		2. Deta of Da Month	aath	Day	Yaar 5	3. Tima of Death
4e. Facility Nama (If not institute PENINSULA REG			NTER				own, or L	ocation of Dae			y of Death COMIC	O
5. Social Security Number 219-76-5129 Usual Rasidanca of Decedant	6. Sex 1 □ M 2 【X F	7. Age (In yrs. 51	last birthday) Yrs.	If Unda Months		If Under Hours	r 24 Hrs. Min.	8. Date of 8i (Month, D	rth a <i>y, Yea</i> 948	ir)	9. Birthp Cour	place (Stata or Foreigntry) Md.
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10e. Street end Number				10f. Zip	Coda				10g. (Citizan of 1	What Cour	itry?
P.O. Box 2358					802				US	T		
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1 ☐ Burial 2 🛣 Cramation 4 ☐ Donation 5 ☐ Other		Stata	cematery, crar			,		-27-99	0.		4~-	Ma
21. Signatura of Funerai Sarvio		A Call	nbridge	2. Name er				1-21-99	Uč	THIDLI	dge,	Md.
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27. Manner of Death 1 ☑ Natural 5 ☐ Pend 2 ☐ Accident Invas	28a. Date (Moi tigation	of Injury oth, Day Year)	28b. Time of Injury	f 2	28c. Injui Woi 1 □	ryat rk? Yes 2 □	No	28d. Describe	how in	jury occur	rred	
3 ☐ Suiclda 6 ☐ Coul	mined 286. Plac	a of Injury - At he ling, atc. (Specif	ome, farm, str (y)	reat, factor	y, offica			28f. Location City or To			ber or Rura	al Route Number,
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29b. Signature and title of cedit		mai stated.		200	c Licens	e number			29d I	Data sinne	ed (Month,	Day Yearl
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State Registrar

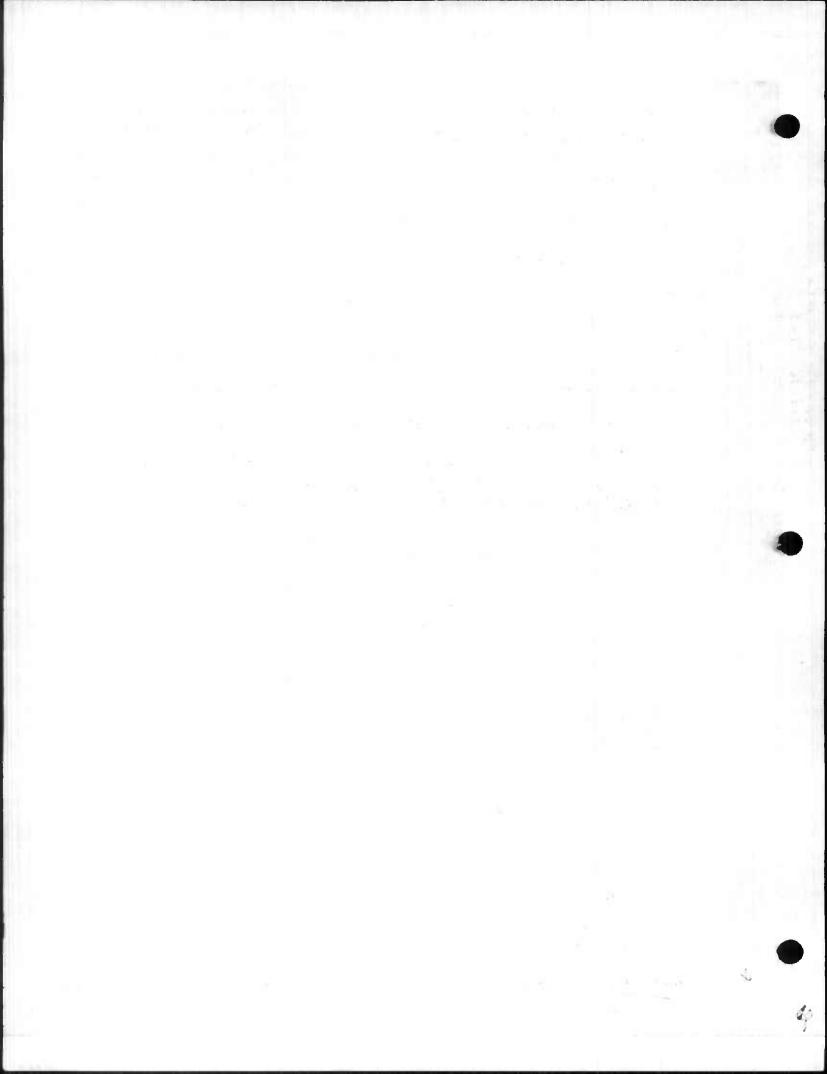
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30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

100 E. CANOIL ST.

SAUSBURY, MD



HOWARD GAINES		110000	State of		/ Departn		lealth a		tal Hyg		15	511
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Nerra Nerra Dec. m	3 ☐ Widowed 4 🕮		12. Wes Decede Armed Force 1 2 Yes 2 If Yes, Give Yeer or Date	es?	tf Yes	Decedent of It, specify Cub	an, Mexican,	gin? (Specify , Puerto Rica	Yes or No- n, etc.)		e - American ek, White, etc Af: Amer:	rican-
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n 22.5	19e. Informent's Neme/				19b. Mailing Ad 730 - 7							
Baltimore semit. Pages 1. Department of He my injury or oth my injury or oth ms.	20e. Method of Dispositi 1 X Buriel 2 Cr. 4 Donetion 5 D	emation 3 🗆		ete cer	ce of Disposition netery, cremetory	or other ple		5/3		20c. Location - Brentwo		
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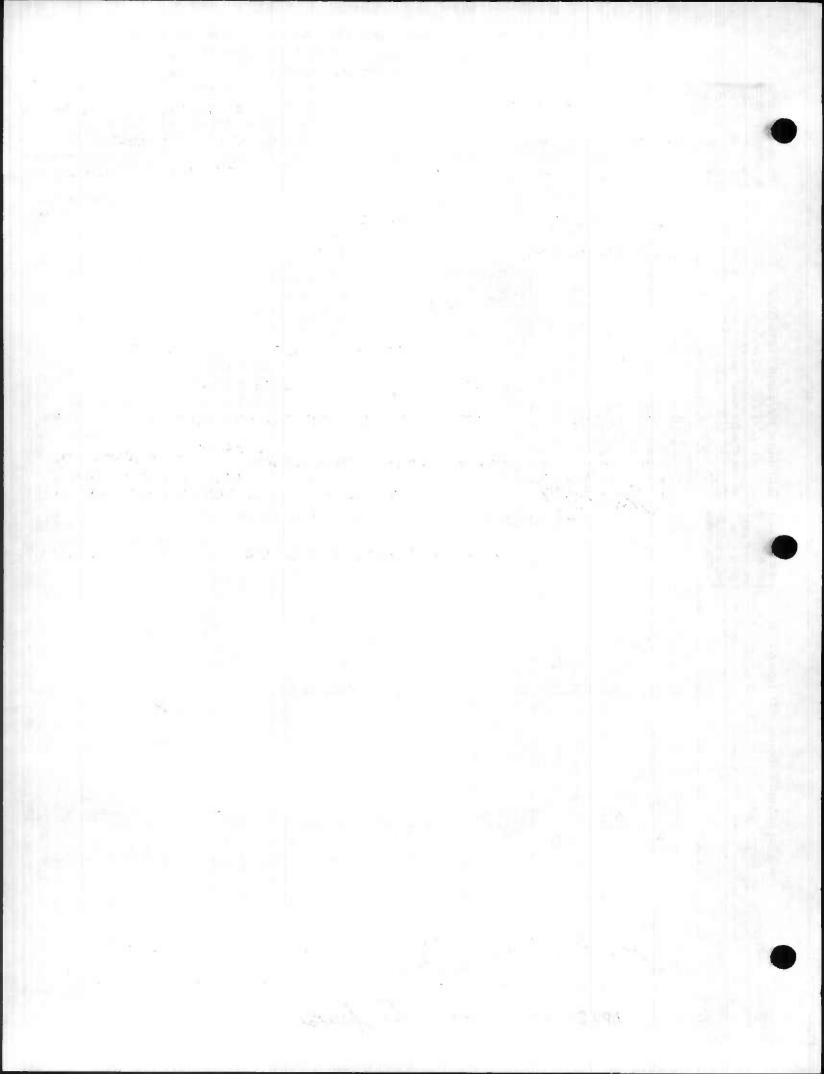
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Month Ves **Physician** GEORGE ELMER HUGG 26, 1999 APRIL 4:20 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) **Examiner** 623 JASONTOWN RD. WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/2/1921 9. Birthplace (Stete or Foreign 5. Sociai Security Number 7. Age (In yrs. last birthday) **Funeral** Days ₩ 2 F Months Hours MARYLAND 77 Yrs 216-16-9426 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner, must be notified at 1 ☐ Yes 2√ No MD. CARROLL WESTMINSTER Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 623 JASONTOWN RD. USA. Funeral permit. Pages 1 and 2 should be filed within 72 hours effer deal Department of Health and Mental Hygiene.
Important: if flem 27 is marked other thems any injury or other traumous 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1∑ Yes 2 □ No If Yes, Give Yeer or Dates: WW II 1 Never Merried 20 Married 1 Yes 2√ No Specify: Specify: WHITE à 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER EDUCATION 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) GEORGE I. HUGG CLARA LONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) JANET C. HUGG WIFE 623 JASONTOWN RD., WESTMINSTER, MD. 21158 20b. Place of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 20e. Method of Disposition 4/29/99 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State FINKSBURG, MD. 4 Donation 5 Other (SpecifyNTOMBMENT EVERGREEN MEM. GARDENS 21. Signature of Funeral Service Licen 22. Name and Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 201 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heert failure. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE /Medical MONTHS **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequenca of): The law requires that the death certificate be exec ng physician of as the buriel P.O. Box 68760, Due to (or as a consequence of) esn for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Was an eutopsy pege 2 After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death filled in by the 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical 29c. Lícense number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifies 1)14311 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) TANEYTOWN LINTHICUM, MD 1 KINGS JRIVE WILLIAM R. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

Registrar **DHMH 16 Rev 6/95**



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth **Physician** Stella F. Hamilton April 27, 1999 1:50 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Union Hospital Elkton Cecil 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 200 F Months Deys Hours Min 212-20-7245 83 Yrs. Feb. 14, 1916 Kentucky Director Usuel Residence of Deceden 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ris 23a or 28a-f show 1 ☐ Yes 2 No Maryland Directo Cecil Colora 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2609 Tome Hwy. items 23a 21917 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14 Rece - American Indian Bleck, White, etc. traumatic evant, the Medical Examiner 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ Yoo Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) marked other than Coltege (1-4or 5+) Hygiene. Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill int of Health end Mental Hits 1f item 27 is marked oth Be Lee O. Frasure Elizabeth Hamilton 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bobby Hamilton/Son PO Box 73 Conowingo, MD 21918 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) New Bridge Baptist Cem. 4-30-99 Rising Sun, Maryland R. T. Foard Funeral Home, P. A. 21. Signature of Funeral Service Licensee 23e. Perti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart teilure. List only one cause or each line. Approximete Interval Between Onset end Death Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Renail Fusuticies Examiner Examiner Deculita ulcer burial-transit certificate be executed pue Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): ettending physician Physician/Medical the COPD 98 P.O. Pert II. Other etgnificsnt conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobscco uss contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Cononly Antey Deer Records. þ 8 24b. Were eutopsy findings sveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy has Hxpollynow Ism. 1 ☐ Yes 2 ☐ No certificete Division of Vital 25. Wes case referred to medical Be 26. Plece of Death (Check only one) exeminer? Hospital: 1 ☐ Impatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 20 No this 28e. Dete of Injury (Month, Dey Yeer) 27. Manner of Death Hospital or Attanding PP 24 hours after death.
 Funeral Director: After the 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 1 Naturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1/2 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner steted. 29a, Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Juichil Han HP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUI CHIH HSL 223 West 10 main & Eller

DHMH 16 Rev 6/95

State

Registrar

31. Dete fited (Month, Day, Year)

APR 2 8 1999

32 Registrer's Signeture

State of Maryland / Department of Health and Mental Hygiene 9

			Ce	rtificate of	Death		Reg. No.	1	0 1 4
		Decedent's Name (First, Middle, Last)				2. Dete of De		Vans	3. Time of Death
	Physician	Pearl	Haywo	ood		Month April	28 1	Year 999	7:00PM
	/Medical Examiner	4e Fecility Neme (If not institution, give street and number)			4b. City, Town, or	Location of Death	4c. County	of Death	
4	Examine	1316 Fenwick Lane			Silver S	pring	Mon	tgom	ery
-	Funeral		e (In yrs. iast birthday	If Under 1 Year		8. Date of Birt (Month, Da			lace (State or Foreign
1	Director	578-62-6105 1 ¹ M 27 F	105 Yrs.	Months Deys	Hours Min.	April 8	1894		h., D.C.
	2	Usual Residence of Decedent							
	nylen thow	10e. State 10b. County	10c. City, Town or L	ocation				1	0d. Inside City Limits
	e Me	Maryland Montgomery		Si	lver Spri	ng			1 □XYes 2 □ No
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21215-0020	ed within 72 hours eff ygiene. ver than "natural", or it, tre Medical Exami	15. Decadent's Education (Specify only highest grade completed)	(Give	edent's Usual Occu	during most of wo	rking	16b. Kind of Bu	siness/inc	lustry
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Baltimore,	permit. Peges 1 end 2 Depertment of Health of Important: If Item 27 is any injury or other tre pnce.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Placa of Disp cemetery, cre	emetory or other pla		Date	20c. Location -	City or 10	wn, State
Ë	men ant:	4 Donation 5 Other (Specify)		vet Ceme	tery	5/4/99	Wash.,	D.C.	
a	ppen poor ny in	21. Signature of Funeral Service Licensee	A 2	22. Name and Addr	ess of Facility	Stewart	Funera	1 Hor	ne .
2	805 2 8	John I. Sleedar	X.([]	4001 Ber	nning Rd.				20019
		23a. Part 1 Enter the disease, or complications that cause shock or heart feilure. List only one cause on each I	d the death. Do not er	nter the mode of dy	lng, such as cardia	or respiratory a	rrest,		Approximate Interval Between
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A	/Medical	Immediate Cause (Final disease or condition	Jolit	nins	10				2 UC
	Examiner	resulting in death)	Due to (or es e conse	equença of):	1 3			1	- 'J'
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	death certificete be executed e attending physician end bd for use as the buriel-transit sician/Medical Examiner	Sequentially list conditions	Due to (coas e conse	equence of)		-			
ó	EX Field	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	oc d.	18 1 -	122	-0		i	
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Records,	requires that seen signed be hould be deta						en eutopsy	24b. W	ere autopsy findings aileble prior to
8	been si should					perio	rmed?	CO	mpletion of ceuse death?
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Vital	Physician: this certific ral director,	25. Was case referred to medical examiner?		-50	ther	ath (Check only o	U_U		
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	To the Hospital or Atten- within 24 hours effer deef To the Funeral Director: completely filled in by the Medical Certifica	29b. Signature and title of certifier	/	29c 1 Ican	ise number		29d. Qate signe	d (Month	Day, Year)
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	(2)	30. Name and address of person who completed cause of	death (Item 23e) (Type	Print)	,	1.0	1	1	20910
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	Registrar	APR 3 0 1999	/J.	DODUNA					

State of Maryland / Department of Health and Mental Hygiene

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	and 2 salth a n 27 la	Rowena Ham	ilton	/ Mother		3200 Wh	isper	ing Pine	s Drive	Silver	Sprin	ng, Md.2090
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1	3/	30. Name and address of	person who	completed cause of c	dath (Item 23a)	(Type, Print)						
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	State	31. Date tiled (Month, D.	ay, Year)	32. Registr	rar's Signature					ore in the	استري	
	Registrar	APR 2	9 1999	1 Den Bern	V 4							

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death April **Physician** 27, ALMA NEAD 8:30am /Medical 4e Facility Neme (If not institution, give street end number) 4h. City. Town, or Location of Death 4c. County of Deeth **Examiner** Magnolia Hall Nursing Home Chestertown Kent If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M **X**)F Yrs. Director 88 207-05-4605 22 1911 Pennsylvania Usuel Residence of Deceden the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at Yes 2 No Director MD Kent Millington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 351 Cypress St. U.S.A. 21651 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) File Clerk Chemical Manuf. 11 permit. Pages 1 and 2 should be file Department of Health end Mental Hy, Important: If Item 27 is marked othe any injury or other traumatic event, 0006a. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be William Nead Viola Wagner 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ann S. Haque (daughter) P.O. Box 18 Millington, MD. 21651 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State Burial 2 □ Cremetion 3 □ Removal from Stete 5/1/99 Three Springs, PA. Cherry Grove Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licen-22. Name end Address of Facility Galena Funeral Home of Stephen Schaech M00510 seese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, lure. List only one cause on each line. 21635 Eyler the Approximate Interval Between Onset end Death Physician /Medical Immediete Cause (Finel CENTRIOURCULA DECIDART 2 Hell disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): attending for use as P.O. signed by the a Part II. Other atgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, þ requires Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Megner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Netural 2 Accident 5 Pending 1 Yes 2 No o 24 hours after death Pruneral Director; A yiely filled in hour death. investigetion 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifie To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier my 11-13824 4.5818 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

John C. Seymour

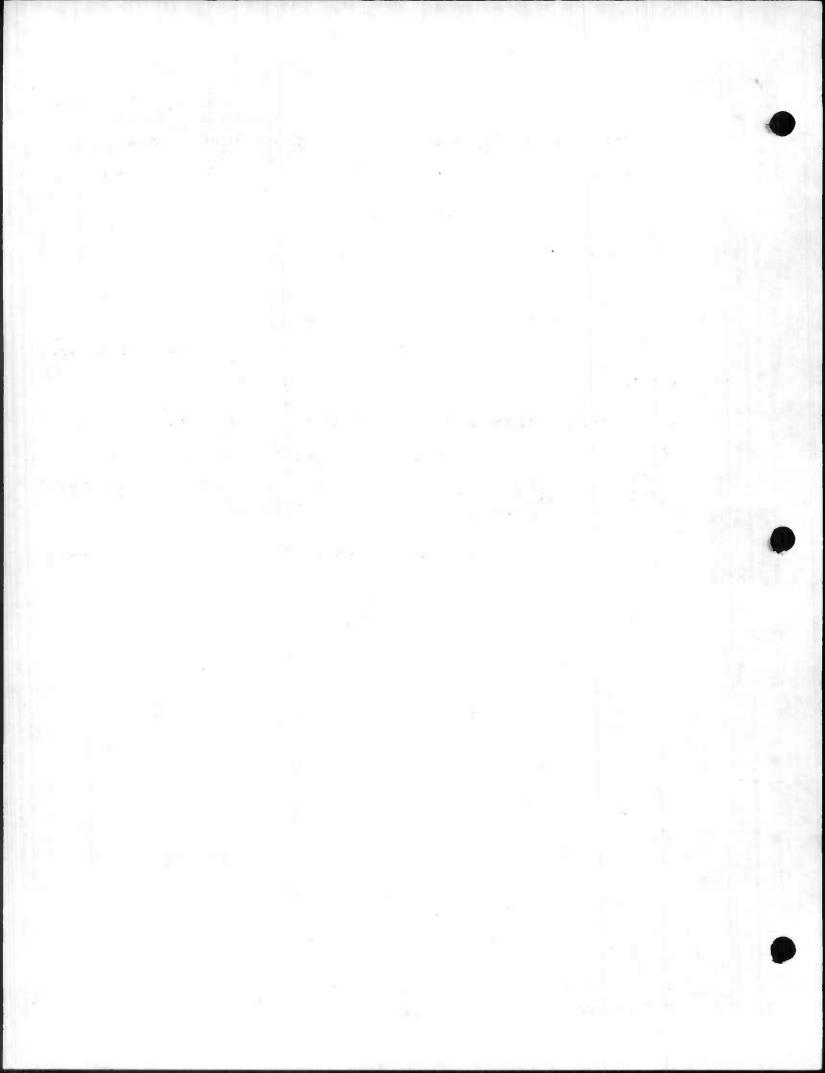
31. Date filed (Month, Day, Year)

MD

32. Registrer's Signeture

DOLLES

122 Speer Rd. Chestertown, MD. 21620



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician EULA** JOHNSON B. April 18, 1999 9:45 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia
If Under 24 Hrs. Howard 8. Date of Birth 9. Birthplace (State or Formatty) Feb. 14, 1943 Marion, S.C. 6. Sex 1 ☐ M 2 ∏ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 56 250-70-2602 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9413 Bull Ring Lane 21045 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a any Injury or other treumstic event, the Medical Exprorer mast once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No if Yes, Give X Year or Dates: Specify: Black 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker N/A 12th 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be 2 Joseph Davis, Sr. Maggie Mae Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Johnson - Daughter 9413 Bull Ring Lane, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 4-24-99 Rains, South Carolina Rains Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011 plications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approxima Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Myocardial Infarction 1 hr. **Examiner** Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Neturel 2 ☐ Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 37013 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) #210 11055 Little Patuxent Parkway, Columbia, MD 21044 Bruce M. Conger, M.D. 32. Registrar's Signature 31. Date filed (Month, Dey, Year) APR 2 8 1999 Sports

Registrar

with the Maryland

Baltimore, Maryland 21215-0020

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Nem 27 is marked other then "natural", or Nems 23s or 28s-1 show other treumstic event, the Modical Exposicer must be not the di-

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Division of Vital Records,

Hospital or Attending Physician:

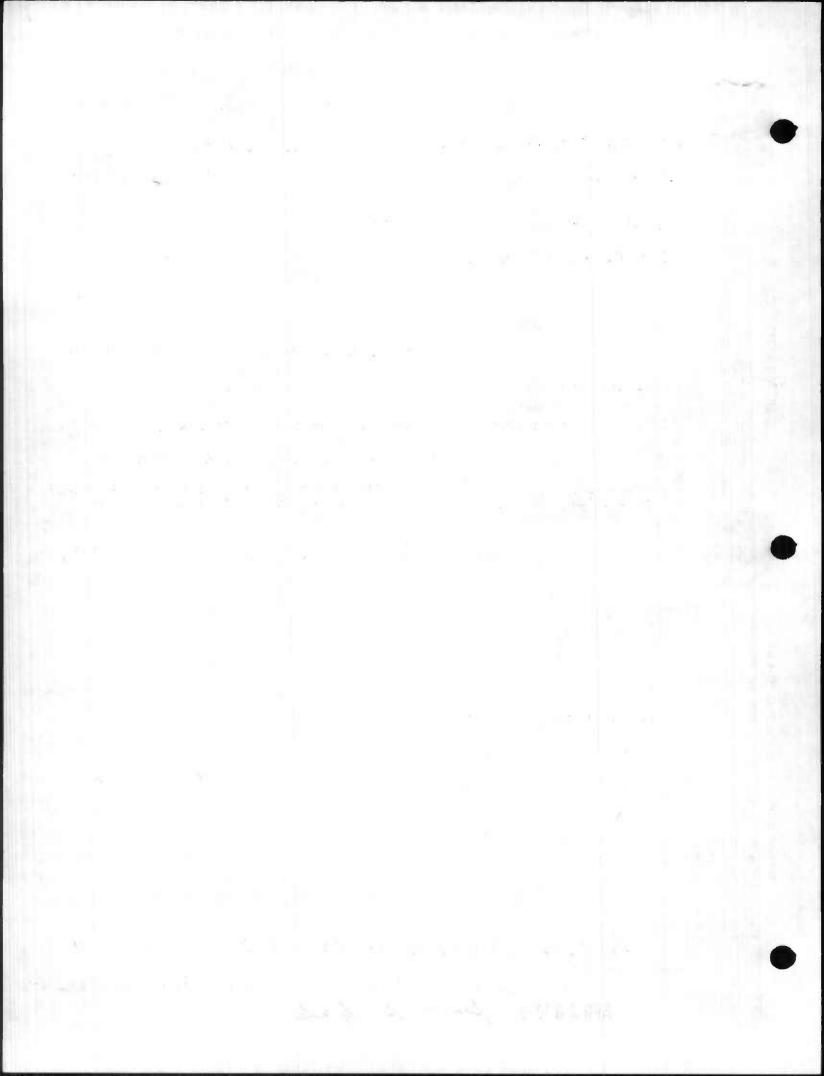
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Day Month Vaar **Physician** 8:14 PM TOHNSON 1999 APRIL LEONARD WILLIAM 26 /Medical 4a Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DALTIMOL ar If Undar 24 Hrs. CIT JUHNS HOSPITAL TOPKINS If Under 1 Yaar 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Say 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** M A P Months Days Hours Min. Yrs. 55 219-38-4735 Director May 23, 1943 Maryland Usuai Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yas 2 € No Directo Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiena. than "natural", or items 23s or the Medical Examiner must be 5845 Mt. Hermon Church Rd. 21804 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1⊠ Yas 2 □ No If Yes, Give Yaar or Dates: 61-63 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Naver Married 2 🕅 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 7 is marked other than traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Extermination Self Employed Exterminator 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Be William E. Johnson Alice Holland 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. informant's Name/Relationship (Type, Print) Health a 5845 Mt. Hermon Church Rd., Salisbury, MD 21804 of Disposition (Name of Date 20c. Location - City or Town, Stata Connie D. Johnson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) permit. Pages Department of Important: If it any injury or or 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 4/29/99 Springhill Memory Gardens 4 ☐ Donation 5 ☐ Other (Specify) Hebron, MD 22. Nama and Address of Facility 21. Signature of Funeral Service Licensee M01051 Holloway Funeral Home Professional Association Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abook, or heart failure. List only one cause on each line. **Physician** /Medical immediate Cause (Final ARREST HOUR disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner requires that the death certificate be executed physician end the buriel-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): attending pl signed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown KIDNEY TRANSPLANT Division of Vital Records, p 24b. Were autopsy findings available prior to completion of causa of death? should 24a. Was an autopsy Completed MELLITUS DIABETES The law certificate hes t lirector, page 2 s 1 Yes 2□ No 1 Yes 2 □ No DISEASE CORONARY Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No 28a. Data of injury (Month, Day Year) funerel 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No deeth. Investigation or Attendation of the order of 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of cartifier alasani Hs RES - 000 April 26, 1999 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 3+1UA SRIDHAR CHAHASAUI NORTH WOLF. STREET BALTIMORE 21287 600 31. Date filed (Month, Day, Year) APR 2 8 1999 32. Registrar's Signature State

DHMH 16 Rav 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene

			C	ertifica	ate of	Death	-		Reg. No.		
1. Decedent's Name (First, Mi	K	raft					Į.	2. Dete of De Month pril	Dey 24, 199		3. Time of Deeth 7:00AM
4a Fecility Neme (If not institu								ation of Deat		y of Death	
10210 Oldfi 5. Social Security Number	eld Driv	_	In yrs. last birthda	If Unc	der 1 Year	Kensi If Under	ngtor	1 3. Date of Bir		gomer	4
165-01-3683 Usual Residence of Decedent	1 X M 2□	DF / Age (87 Yrs.	Month	s Deys	Hours	Min.	(Month, De	y, Year)	2 Penn	place (Stete or Foreigntry) u sylvania
10e. State 10b. Cou		1	Oc. City, Town or	Location	F		-			T	10d. Inside City Limit
Maryland Mon	tgomery		Kensin	gton							1 X Yes 2 □ No
Maryland Mon 10e. Street end Number 10210 Oldfi 11. Maritel Stetus 1 □ Never Married 2 🛣 N				10f. 2	Zip Code				10g. Citizen of	What Cou	ntry?
10210 Oldfi	eld Driv	e		2	0895				U.S.A		
11. Maritel Stetus	Arm	Decadent Eve	er in U,S. 1	3. Was Dec	cedent of h	lispanic Ori an, Mexicar	igin? (Spec	ify Yes or No ican, etc.)	14. Ra	ce - Ameri	can Indian,
1 ☐ Never Married 2 N N 3 ☐ Widowed 4 ☐ Divore	ferried 1 X	Yes 2 □ No es, Give	WII		2 ▼ No	Specify:				⁄፦ Whi	
3 Widowed 4 Divord 15. Dece (Specify only hig Elementery/Secondary (0-1: 12 17. Fether's Neme (First, Midde	dent's Education shest grede comple	eted)) (G	cedent's Usive kind of	work done	durina mos	t of workin	9	16b. Kind of I		
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12 17. Fether's Neme (First, Midd	fle (ast)		Te	rmina	T Mar		ar's Name	(First Middle	Compa		
Anthony Kr	aft					Anni	e Whi	te			
Nita G. Kra		t)							on, MD		
20a. Method of Disposition			20b. Plece of Dis	sposition (A	leme of	ce)	Ī	Dete	20c. Location	- City or T	own, Stete
1 Buriel 2 Cremetic		from Stete	Nationa				4/	26/99	Falls	Chur	ch, VA
21. Signature of Funeral Serv	ice Licenses	2		22. Neme	end Addre	ess of Fecili	s Son		4,101		nsin Ave.
23a Part Enter the disease of heart feilure.	, or complications List only one cause		e deeth. Do not	enter the m	ode of dyl				errest,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approximete Intervel Between Onset and Death
disease or condition resulting in deeth)	θ		ue to (or es e con								
			rette Sm							5	0 years
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	G	Du	e to (or es e cons	sequence o	of):						
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		7						24a. Wes	en eutopsy ormed?	6	Vere eutopsy findings velleble prior to ompletion of cause f deeth?
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25. Wes case referred to med exeminer?	ical					26. Plec	e of Deeth	(Check only	one)		
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3 Suicide 6 □ Cou	estigation uld not be ermined 28e.	Dete of Injury (Month, Day Y Plece of Injury building, etc. (- At home, farm,	М		ryat rk?]Yes 2□	No	8f. Location (Now Injury occi (Street and Nun wn, Stete)		ral Route Number,
29a. Certifier 15 Cartif	lying Physicien: T	To the best of n	ny knowledge, de	eth occurre	ed et the ti	me, date er	nd pieca, ei	nd due to the	ceuse(s) and r	nenner es	stated. to the ceuse(s)
one) 29b. Signature and the obcard	The state of the s	I manner state			STATISTICS.	se number			29d. Date sign		
Veel	. Ten	rengt	on m	0	D2111				April :		
Lee R. Pennin	gton, M.I	//	th (Itém 23e) (Typ)2 Shield		ive,	Bethe	sda,	MD 208	317		
31. Date filed (Month, Day, Ye	IQQQ	37. Registrer's									
	gton, M.I	D 560	2 Shield	ds Dr	ive,		sda,	MD 208	317		

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year Hudre 4b. City, Town, or Location of Deeth 20, 1999 4c. County of Death 1999 /Medical 4e. Fecility Neme (If not Institution, give street and number) Examiner Hunder 1 Year | Hunder 24 Hrs | Month, Medical TENINSULA WICOMICO 5. Sociel Security Number 7. Age (In yrs. last birthdey) Yrs. Birthplece (Stete or Foreign Country) **Funeral** 1 M 2 M 219-07-6095 Director Usuei Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Haaith and Mentai Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examines must be not the an 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director ma. SomeRSET 10e. Street end Number 10f. Zlp Coda 10g. Citizen of What Country? 28739 di 1853 4514 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 22 No If Yes, Give Yeer or Detes: 11. Mantel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Culpan, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1□ Yes 2₽No Completed by Specify: 3€ Widowed 4 Divorced 18e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elamentery/Şecondary (0-12) Collaga (1-4or 5+) VREEN 6 Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Malden Sumeme) Be JONES Kome 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PR. ANNE Rd 28 73 9 Polk.
20b. Place of Disposition (Name of cometer, cremetory or other place)
5t. James Ch. (-11/IAN M, 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removal from State Mes Ch. Cem. 4/24/99
22. Name end Address of Fecility 3 c noise 4/24/99 Mt. VERNON 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 23e. Pert1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Onset end Deeth **Physician** /Medicai Immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? After this cartificate has of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Daeth (Check only one) examinar? Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No To the Hospital or Attending Physi-within 24 hours aftar death. To the Funeral Director: After this c completaly filled in by the funaral dir Certification: To 1- Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Data of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the causa(s) and mannar as steled.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daath occurred et the time, date end plece, end due to the causa(s) and menner steled. Medical (Check only 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Na Bluff Rd. 40-Nam e and address of pego 23a) (Type, Print)

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32. Florighter's Signeture

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State

31. Dete filed (Month, Day, Year)

APR 27



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** 1, MAY 1999 SISTER REGIS KEEFFE 7:25 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner VILLA ST. MICHAEL **EMMITSBURG** FREDERICK Hours Min. 8. Dete of Birth (Month, Day, Year)
DEC.2, 1908 If Under 1 Year 9. Birthplace (Stete or Foreign Country) RHODE ISLAND 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Deys 1 □ M 2 🖫 F Director 216-54-0006 90 Usuei Residence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "netural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MARYLAND FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 end 2 should be filed within 72 hours after death v Depertment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or there 23a eny liqury or other treumatic event, the Medical Example 2008. 333 SOUTH SETON AVE. 21727 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 ☐ Yes 2 💢 No if Yes, Give Yeer or Detes: 1X Never Merried 2 Merried Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DAUGHTERS OF CHARITY Elementery/Secondery (0-12) College (1-4or 5+) 12 CHILD CARE 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) 2 PATRICK KEEFFE ANNIE MARIA HANLEY 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 333 S. SETON AVE., EMMITSBURG, MD. 21727 SISTER CAMILLA HARANT 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1)☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) EMMITSBURG, MD. 21727 ST. JOSEPH'S 5/4/99 22. Neme end Address of Fecility SKILES FUNERAL HOME MIAN ST., EMMITSBURG, MD. 21727 210 W. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart fellure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** /Medical Immediete Cause (Finei disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consequenca of): use as t jo signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown ò 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to completion of ceuse of death? Completed peed certificate Division of Vital funeral director, 25. Wes case referred to medical Be 28. Placa of Deeth (Check only one) Hospitel: Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturei death. 1 Yes 2 No 2 Accident or Attendation after death 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 | Homicide Hospital of 24 hours a Funeral D 29e. Certifier To the Hosp within 24 hos To the Fune completely fi Medical 1XI Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. (Check only 2 Madical Examinar: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. 29b. Signature/s 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print) ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727 1999 Registra's Signeture 31. Dete filed (Month. State Registrar

DHMH 16 Rev 6/95

		ate of Maryland / Dep Ce	ertificate of		Re	g. No.	155	23
hysician /Medical	Decedent's Name (First, Middle, Last) Loren Eugene Linn				-	Dey 19		ne of Death
xaminer	4a Facility Name (If not institution, give street	end number)		4b. City, Town, or Lo Elkton	ocátion of Deeth	4c. County		
neral ector	Union Hospital 5. Social Security Number 511-05-1021 6. Sex	7. Age (In yrs. lest birthdey) If Under 1 Year Months Days	If Under 24 Hrs.	8. Dete of Birth (Month, Day, Luary 7,	Year)	9. Birthplace (S Country) Kansas	ate or Foreign
•	Usual Residence of Decedent						1	
-	10a. State 10b. County	10c. City, Town or L						de City Limits
Scto	Maryland Cecil	Chesapea	10f. Zip Code		10	g. Citizen of W		
급	10e. Street and Number		21915				States	
by Funeral Director	Ar 1 □ Never Married 2 ☑ Married 1 □	as Decedent Ever in U.S. med Forces? Yes, 2 Mo Yes, Give ser or Dates:		dispanic Origin? (Sp an, Mexicen, Puerto Specify:		14. Race	e - American India k, White, etc.	an,
Completed	15. Decedent's Educetion (Specify only highest grede com, Elementery/Secondary (0-12)	pleted) 16e. Dec. (Giv. life. bliege (1-4or 5+)	edent's Usual Occup e kind of work done DO NOT use ratire	oation during most of work d)	ing	6b. Kind of Bu	siness/industry	
201			nic Chemis			Chemic		
Be	17. Father's Neme (First, Middle, Last)				e (First, Middle, M		e)	
0	Jesse M. Linn		No. Add		P. Stewa		Chain 7'- Cod :	
	19a. Informant's Name/Relationship (Type, Pr			reet, Ches				21915
	Gertrude S. Linn/Wi 20a. Method of Disposition 1 Burial 2 MCremation 3 Remov 4 Donation 5 Other (Specify)	20b. Place of Disposer cemetery, cre		ce)	Dafe 2		City or Town, Sta	
	21. Signature of Funeral Service Licensee	H		for Fune			aryland	21921
d by Physician/Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thef initiated events resulting in death) Last d	Acute Pulma Due to (or as a conse Due to (or as a conse	equence of):	l				
Cia	Pert II. Other significant conditions contributi	no to death but not resulting in the	underlying cause giv	ven in Pert I	23b. Did tob	acco use cor	ntribute to the ca	use of death?
by Physician/M	(1 0	Lionyopathy	aridonying coddo gri			8 2□ No	3 ☐ Probably	11
Completed I	-				24a. Was en perform	autopsy ed?	24b. Were auto evailable completio of death?	opsy findings prior to in of ceuse
200					1 ☐ Yes	s 2 No	1 ☐ Yes	2□ No
Be	25. Wes cese referred to medical exeminer?	Al	Out		h (Check only one)		
tion: To	1 Yes 2 No Hospita 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	a. Date of Injury (Month, Day Year) 2 □ ER/Outpatie 28b. Time Injury	of 28c. Inju		ome 5 Resider 28d. Describe how			
Certification:	3 Suicide 6 Could not be determined 286	Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (Str. City or Town,		er or Rural Route	Number,
edical	(Check only 2 Medical Examiner: 0	To the best of my knowledge, dea in the basis of examination and/or in and manner stated.	th occurred at the til nvestigation, In my o	me, date and placa, opinion, death occur	end due to the car red at the time, da	use(s) and ma te and plece,	anner es stated. end due to fhe ce	use(s)
Σ	29b. Signeture and title of certifier	1,16	29c. Licens	se number	29	d. Date signe	d (Month, Day, Yo	ear)
	30. Name and address of person who complete						30, 199	99
	Christopher H. Wend	el, M.D., 111 We	st High S	Street, El	Lkton, Ma	ryland	21921	
State Istrar	31. Dete filed (Month, Day, Yeer)	32. Registrar's Signature	South					

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Month Day SHARON LAVERNE LDCKE 5:05 pm 1PRIL /Medical 4c. County of Death 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGES H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 2, 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 KF Washington, D.C Yrs. Director 579-76-9055 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Prince George's Temple Hills Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? or hems 23s or UnitedStates 20748 5957 Fisher Rd. #102 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedenl of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status I ☐ Yes 2 ☑ No If Yes, Give 1X Never Married 2 ☐ Merried Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) parmit. Peges 1 and 2 should be filled w. Department of Health and Mentel Hygien Important: If Item 27 is marked other thy any Injury or other traumette event. Private 12 Secretary 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) Be Essie Harvey Marshall Locke 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Thomasine Mobley Sister 1709 Linden Park Pl. Mitchelville, Md. 20e. Method of Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, Stete cometery, cremetery or other place)
Maryland National Cem. 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4/26/99 Laurel, Md. 4 ☐ Donelion 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Licens 23a. Part F. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 5538 Marlboro Pike/Forestville, Maryland 20747 Approximete Interval Between Onset and Deeth **Physician** Metastatic Liver /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner adeno carcinoma nding physician and use as the buriel-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? by the 1 Yes 2 No 3 Probably 4 Junknown signed b Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen 1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 12 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of parson who completed and of deeth (Item 23a) (Type, Print).

Caged: Potter 12 1328 Southern Ame SE Washrayton. D. C. 31. Date filed (Month, Day, Year) 2. Registrer's Signeture State APR 2 7 1999 Registrar

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8-34, 1 - - 3

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1999 ar **Physician** 27° 2:50 PM BARBARA LUCAS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 21 F 577-54-6416 60 Yrs. Director Aug. 8, 1938 Washington, DC Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Directo Maryland Prince Georges Adelphi 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Counfry? 2507 Killdeer Avenue 20783 U.S.A. Funeral Raca - American Indian, Black, Whife, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedenf Ever in U,S. Armed Forces? 11 Marifal Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Technician Dept. of Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if Item 27 Is marked oth
any Injury or other traumatic event Be Pauline Robinson Theodore Minor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Allan E. Lucas - Husband 2507 Killdeer Ave., Adelphi, MD 20783 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/3/99 Brentwood, MD 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licansee 4217 9th Street N.W. Washington, DC 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final METASTATIC BREAST CARCINOMA 3 YRS. disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lasf Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 □ Yes 2 □ No certificata Vital or Attending Physician: Be 25. Was case referred to medical 28. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Unpatient Medical Certification: To 2 ER/Outpatient 3 DOA Division of this Junaral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Panding Investigation after death. 1 ☐ Yes 2 ☐ No 6 Could nof be determined 3 Suicide 28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, dafe and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Cartifier completely (Check only one) To the ŝ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 APRIL 28,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 VICTORM. PRIEGO, M.D.

State Registrar

31. Date filed (Month, Day, Year) APR 3 0 1999

DHMH 16 Rev 6/95

27-99

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UCAS, Barbara

6410

32. Registrar's Signafure

ROCKLEDGE DR. # 625 BETHESOA, MD. 20817

E. W. SIR.

State of Maryland / Department of Health and Mental Hygiene 00

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** HELEN B. LATIMER APRIL 23, 1999 5:45 A.M. /Medicai 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth MONTGOMERY 4b. City. Town, or Location of Deeth Examiner BETHESDA SUBURBAN HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthpiece (Stete or Foreign Country) OCT. 15, 1904 WASHINGTON, DC If Under 1 Yaar If Under 24 Hrs. 5. Sociei Security Number 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign **Funeral** Deys Hours 1 □ M 2)② F 94 216-58-5915 Yrs Director Usuei Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits MD MONTGOMERY ROCKVILLE 1 Yas 2 No Director 10f. Zip Code 20852 10e. Street end Number 10g. Citizen of Whet Country? 6300 POINDEXTER LANE U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No if Yes, Give Yaer or Dates: 14. Race - American Indien, Bieck, Whita, etc. Was Decedent of Hispanic Orlgin? (Spacify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Never Merried 2 ☐ Merried Specify: WHITE 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) MINNIE EVA OLIVER ROBERT E. BECKHAM 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 110 KINGSLEY ROAD, SW, VIENNA, VA 22180 SON HENRY B. LATIMER 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Ramovel from Stete 4/28/99 WASHINGTON, D.C. OAK HILL CEMETERY 4 ☐ Donetion 5 ☐ Other (Special) 21. Signature of Aunerel Sarvice Licensee JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVENUE WASHINGTON, D.C. 20016

23e. Pent. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Approximeta intervel Betw Onsat and Death **Physician** /Medical Immediate Ceuse (Finel CARDIO PULMONARY ARREST disease or condition resulting in deeth) Examiner Due to (or as e consequence of): MULTIPLE SYSTEM ORGAN FAILURE Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): SMALL BOWEL OBSTRUCTION Physician/Medical Due to (or es a consequence of): Part ii. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert i. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes en autopsy performed? Completed 1 Yes 2√ No 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 10 1 Yas 2 No 1 N Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of injury (Month, Dey Yeer) 27. Menner of Death Medical Certification: 28b. Tima of 28c. injury et Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 Yes 2 No investigetion 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted. 29b. Signeture end title of certifier 29c. Licensa number 29d. Dete signed (Month, Day, Year) 50721 30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print) DR. WILLIAM T. THISTLETHWAITE, M.D. 6410 ROCKLEDGE DR. #403, BETHESDA, MD 20817 31. Deta filad (Month, Dey, Year) State

Registrar

APR 2 9 1999

32 Registrar's Signeture

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Atme

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.23.99

Box 68760,

Records,

of Vital

Division

Attending Physician:

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Movicel Examination must be notified as

permit. Pages 1 and 2 should be filed within ? Department of Health and Mentel Hygiane. Important: If Nem 27 is marked other than "n any injury or other traumatic event."

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To the Hospital or Att within 24 hours after d To the Funeral Direct

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day WILLIAM April 23,1999 LUDWIG 11:55 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 34361 Parker Place Pittsville Wicomico If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) Min 1 M 2□ F Months Days Hours Yrs. 62 November 15,1936 Maryland Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits Wicomico Pittsville 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 34361 Parker Place 21850 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bieck, White, etc. 1 XYes 2 ☐ No If Yes, Give Yaar or Datas: 1 Never Married 2 Married White 1 ☐ Yes 21 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Army 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Postal Service Worker 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Joseph Ludwig Sr. Anna M. Garey 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) Melita M. Ludwig/Wife 34361 Parker Place, Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 4/27/99 Hebron, MD 5-TOthar (Specify) Springhill Memory Cardens of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Sport Hill Rd., Salisbury, MD 21804

Appropriate List only one ceuse on each line.

Soliable Fiolessional Associated the death. Do not enter the mode of dying, such as cardiac or respiratory errest.

Appropriate Fiolessional Associated the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximata Interval Between Onset and Death Due to (q Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last Due to (or as a consequance of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ehow solds! Examiner must be notified at

7 is marked other than "natur traumatic event, the Medical

or other 1

permit. Page Depertment important: If eny injury o once.

Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiena. nt: If item 27 is marked other than "naturel", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

WALTER

5. Social Security Number

Maryland

11. Marital Status

10e. Street end Number

20a. Mathod of Disposition

Immediate Ceuse (Finai disaase or condition rasulting in death)

25. Was case referred to medicel

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 ANaturai

2 Accident

3 Suicide

29a. Cartifian

edical

4 ☐ Homicida

(Check only one)

10e State

Director

Funeral

þ

Completed

Be

212-34-2547

Examiner end I-transit attending physician e for use as the burial-Physiclan/Medical isigned by the ai à should s Completed page 2 is certificete? Be 2 this

The law requires that the death certificate be assecuted Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: funeral Certification: After death. ector: / filled in by after To the Hospital within 24 hours a To the Funeral Completely filled

10+1VA

State

31. Date fliad (Month

5 Pending investigation

6 Could not be determined

na

29c. Licensa number

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Spacify)

20057

29d. Date signed (Month, Dey, Year)

30. Name end eddrass of person who completed ceusa of death (Item 23a) (Type, Print) 32. Registrar's Signeture

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

1 Inpatiant

28e. Date of Injury (Month, Dey Year)

en licemine

G Revensed

28c. injury el Work?

1 Yes 2 No

Registrar **DHMH 16 Rev 6/95**

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 € Unknown

24a. Was an eutopsy

Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify)

26. Piece of Death (Check only one)

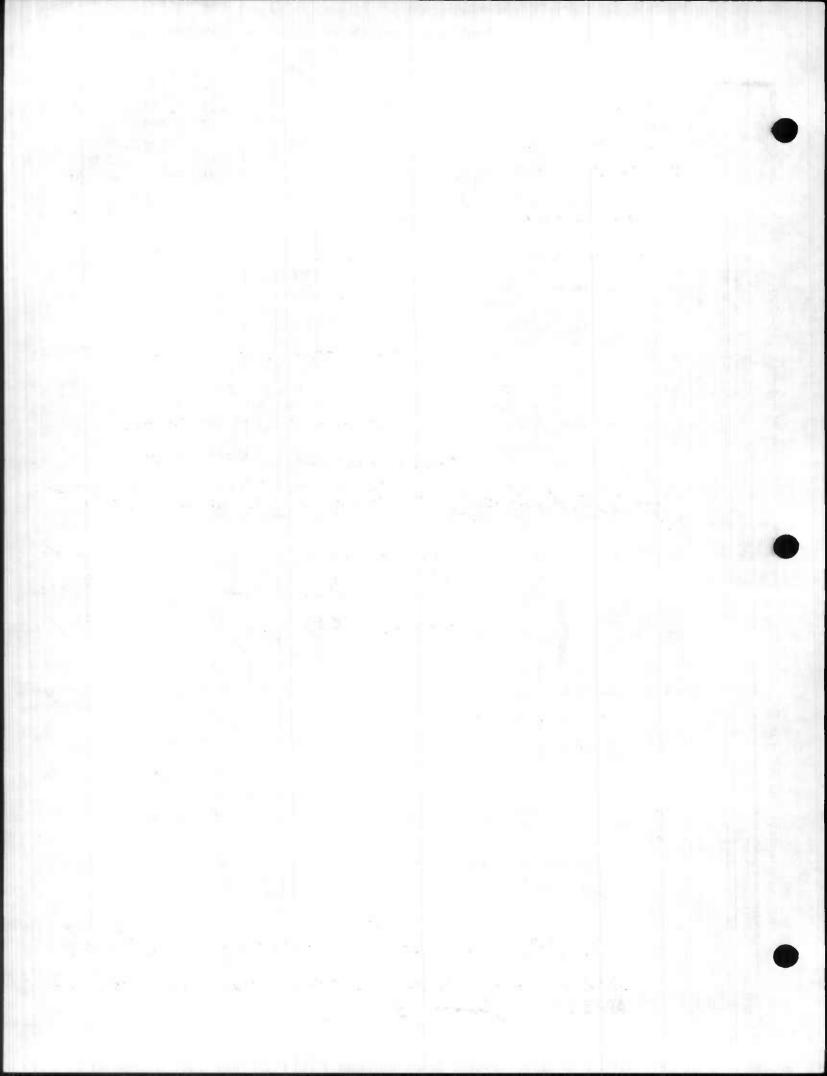
1 Yes 2 No

28d. Describe how injury occurred

24b. Wara autopsy findings eveilable prior to complation of cause of death?

1 ☐ Yes 2 No

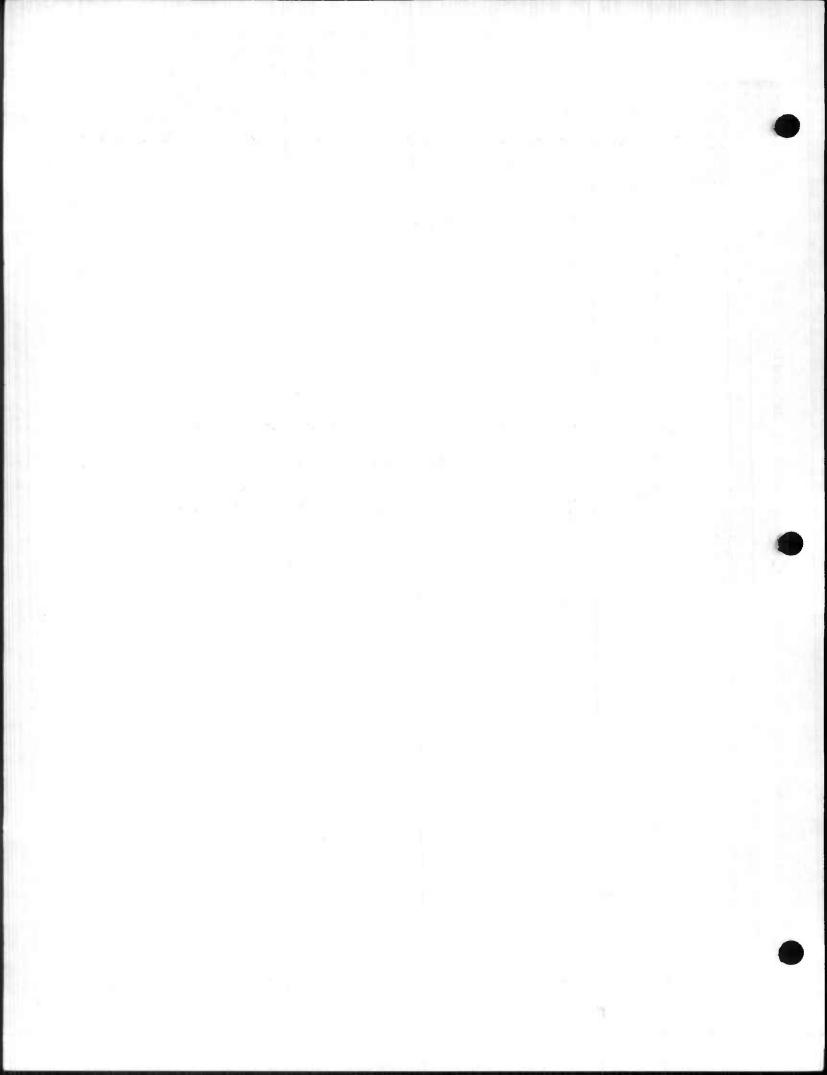
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

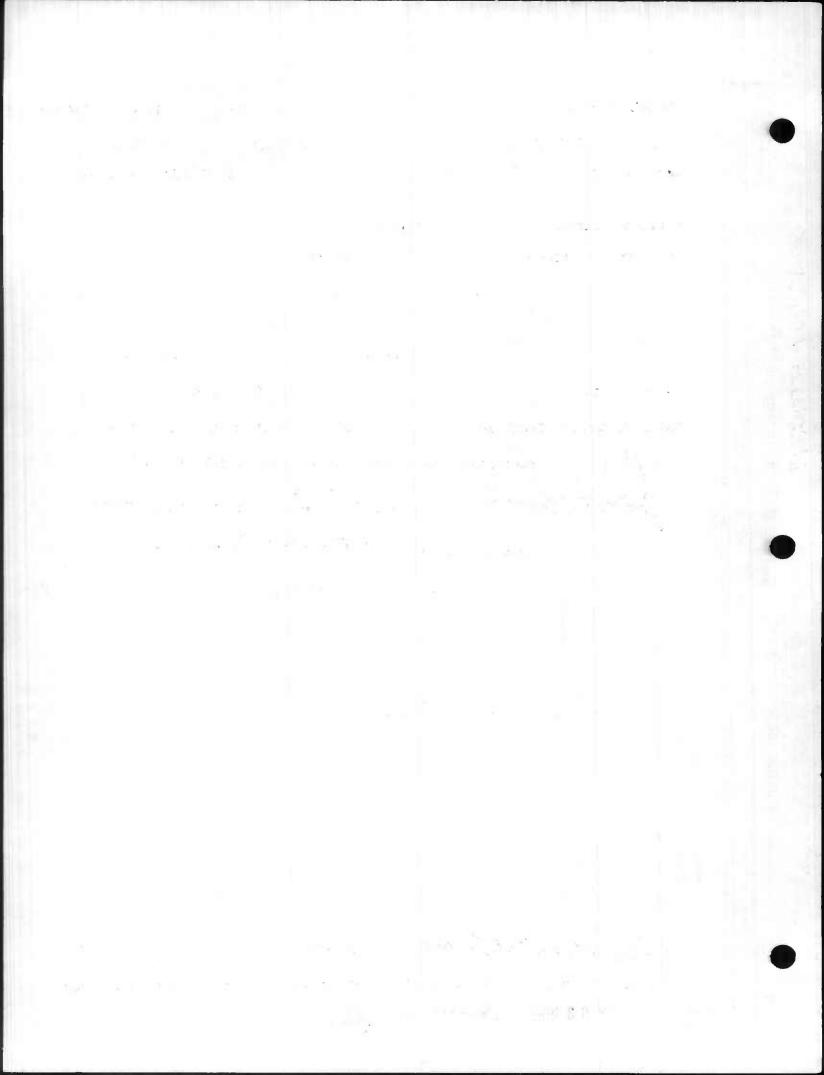
				State of Marylar		rtificate of			Reg. No.	15.	28
Phys	sicia edica	_	Decedent's Name (First, Middle, Last) ADA MAE	LOWMAN				2. Date of Dea Month May	Day	Year	Time the the 2300 FM
	mine	_	4a. Facility Name (If not institution, give str	eet and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			Shady Grove Adv	entist Hos	spital		Rockvil	le MD	Mon	tgomer	. A
Fune Direct			5. Social Security Number 6. Sex 214-48-2732 Usual Residence of Decedent	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 29	Year) , 1917	9. Birthplace Country) Maryla	(State or Foreign and
nyland			10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			180		side City Limits
e Me		Director	Maryland Frederic	K M	t. Air	У				1	X Yes 2 □ No
F 20 5			10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?	
23a			13406 Penn Shop Ro	ad		217	71_		United	States	
permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show sayl follury or other traumatic event, the Mencal Exercise manages.		by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever In U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2℃ No	tispanic Orlgin? (Sp an, Mexicen, Puerto Specify:	pecify Yes or No- Rican, etc.)	Blac	a - American Inck, White, etc. white	dian,
d 2 should be filed within 72 hours ef than A Mental Hygiene. 77 a marked other than "natural", or traumalic event, in Model Exp.		Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	tion om <i>pleted)</i> College (1-4or 5+)	(Giva	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Kind of Bu	usiness/Industry	
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ital H		e n	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumem	ne)	
Men		<u> </u>	Lester Moxley				Lottie	Mae Bu	rdette		
2 sh and is m			19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	ng Address (Street	and Number or Ru	rel Route Numbe	r, City or Town,	State, Zip Cod	a)
vermit. Peges 1 and Department of Health mportant: If itsm 27 any injury or other ti			Ruth Ann Lowman, 20a. Method of Disposition ↑CRBurial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	20b. I	Place of Dispo	6 Penn S sition (Name of natory or other pla	1	Mt Air	y, Mary 20c. Location -		1771 State
tant	1,					ove Ceme		5/5/99	Mt. Air	y, Mary	land
Depermination of the permination	once		21. Signature of Funeral Service Libensee	Survey		. Name and Addre	Sta	uffer F	uneral 1	Homes,	
Physicia /Medic	_		23s Farty Enter the disease, or complica shook, or heart facture. List only one Immediate Cause (Final	tions that caused the deal cause on each line	. Do not ent	er the mode of dyli	ng, such as cerdiac	or respiratory ar	rest,	App Inte Ons	771 roximate val Between et and Death
Examin	er		disease or condition resulting in deeth) a	Sepsis Due to (or as a conseq	uence of):				ho	urs
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leath cer ettendin I for use		Physician	d								
es thet the death cert igned by the ettendin be deteched for use		Dy Phys	Part II. Other significant conditions contril	buting to death but not res	suiting in the ur	nderlying cause giv	ren in Part I.	236. Did t	_/		cause of death?
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								1 🗆 Y	es 2 No	1 ☐ Yes	2□ No
clan: ertific ector,		0	25. Was cese referred to medicel examiner?	nital.		1,-	26. Piece of Dear	th (Check only o	ne)		
Physician: The lar or this certificate has eral director, pege 2	ı	2	1 Yes 2 No Hos		ER/Outpatien		4 Li Nursing He	ome 5 ☐ Resid			
Attending Physician: or death. ector: After this certific by the funeral director,		ation:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	Wo	yat rk? Yes 2 □ No	28d. Describe h	ow Injury occur	red	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	(y) 			28f. Location (S City or Tow	n, State)		
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		edical	(Check only 2 Medical Examiner one)	an: To the best of my kno ; On the basis of examina and manner stated.	owledge, death ation end/or Inv	occurred at the tir restigation, in my o	ne, dete and place, plnion, death occur	and due to the c red at the time, c	ause(s) and ma date and place,	and due to the	ceuse(s)
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			30. In man and address of person who comp	pleted cause of death (Iter	n 23e) (Type,	Print)	ical C		- New	P = 1	1112
	State	2	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	4	Call	ENTE		ICOCK	20850

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death Month . MURRAY and number) CONVALESCENT **Physician** TELLA /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner WESTMINSTER (If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) PARROLL CENTER | birthday) If Under 1 Year NURSING AND 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday) 8 Yrs. 9. Birthplace (State or Foreign Country) Months Deys Director Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itama 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director ESTMINSTE 10g. Citizen of Whet Country? 10e. Street end Number USA SHINGTON KOAD parmit. Pages 1 and 2 should be filed within 72 hours after deeth variantment of Health end Mental Hygiena. Important: if from 27 is merked other than "natural", or frama 23. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Maritai Status Bieck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1□Yes 2□No Specify: WHITE Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) ASHIER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be OZEFA STANISLAW HOROCH OF SKA IRESOWATY 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SON THEODORE MUR 20b. Placa of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 20a. Method of Disposition 1 Deturiet 2 □ Cremation 3 ■ Removel from State CAMBEN, 11/99 NEW ST. MARY CEM. 4 ☐ Donation 5 ☐ Other (Specify) any injury 22. Name and Address of Fecility PRIHS FUNERAL HOME & ChapE re of Funeral Service Licensee 412 WASHINGTON ROAD Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** immediate Cause (Final disease or condition resulting in death) /Medical arrator Examiner Physician/Medical Examiner attending physician and for use as the bunel-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or es e consequence of): use as t 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 s 2 No 1 ☐ Yes certificata or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 10 2 No Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this s 28a. Date of Injury (Month, Day Year) funerel 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Maturat 2 ☐ Accident 5 Pending 1 Yes 2 No 24 hours after deeth. investigation 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. Medicai completaly 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Illia of certifier

State Registrar

strar APR 2 8 1999

31. Date filed (Month, Day, Year)

Wishing

32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

9. Sparks

altimore, Maryland 21215-0020

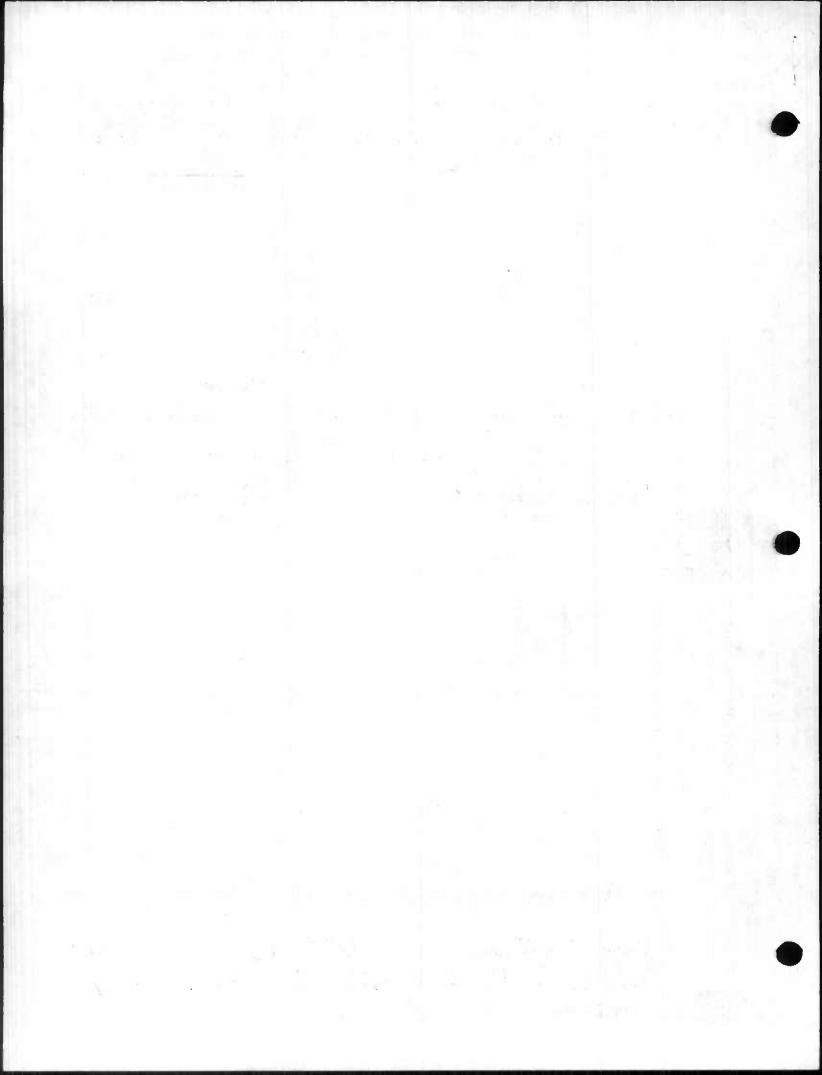
Division of Vital Records, P.O. Box 68760,

MISSEL PITTS TO TENE While total great and the superior of the control of 186 189 194 II got prop Laur Parade President unt the Marinder gare - Alex STRINSTER TRANSPORT Tak trong Marck, Sail Electron and March Edward St. Markey Clinical Control of the Control o And the second of the second o

Amended Items 7 & 8, Per F.D. State of Maryland / Department of Health and Mental Hygiene 0 5/3/99, Carroll County, wil Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** April 2Pay Leotta Pauline MacDermott 3:40PM /Medical 4a. Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Westminster Nursing & Rehabilitative Ctr. Westminster Carrol1 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 8. Data of Birth (Month, Dey, Yaar) 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foreign Country) Virginia Funeral 1 □ M 2 □XE 95 96 215-44-1642 Yrs. Director 31, Usual Residenca of Decadant Oct. the Maryland 10e. Stata 10b. County 10c. City, Town or Location 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at Director 157 Yes 2 No Maryland Carrol1 Union Bridge 10e. Street and Number 10f. Zip Coda 10g. Citlzan of What Country? ò 6 S. Main St. 21791 U.S.A. items 23a Funeral death 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas: Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - Amarican Indien, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yas 2 ☐ No Specify: þ Specify: 3 X Widowad 4 ☐ Divorced White Be Completed 15. Dacedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT use retired) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 is marked other any injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Paul Glover Hattie Stoner 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Straat and Number or Rural Route Number, City or Town, Stete, Zip Coda) James L. MacDermott/ son 550 Mount Holly Dr. Westminster, MD 21157 20e. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or othar place) 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☑ Crametion 3 ☐ Ramovel from Stata Carroll Cremation, Inc. 4/29/99 Hampstead, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Fecility e of Funeral Service License Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse are not line. Approximate Intervel Batween Onset and Death **Physician** /Medical Immediete Causa (Final SCUT disaese or condition rasulting in death) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use as the bunel-transit Sequantially list conditions, if any, leading to immediate causa. Entar Undarlying Ceusa (Disaasa or Injury that Initiated avants rasulting in death) Last P.O. Box 68760. to (or es e consequanca of) be deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 2 1 Yss 2 No 3 Probably 4 Unknown Records, þ page 2 should 24b. Wara autopsy findings avellabla prior to complation of causa of death? Completed 24e. Was an autopsy performed? 1 Yas 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifics Be 25. Was case rafarrad to medical examinar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Deeth 1 Watural Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 5 Pending Invastigation 1 ☐ Yes 2 ☐ No the ! 2 Accident 6 Could not be datermined 3 ☐ Suicida 28a. Placa of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicida 1 Cartifying Physician: To tha bast of my knowledga, daath occurred at the time, deta and place, and due to tha cause(s) and mennar as stated.
2 Medical Examinar: On tha basts of exemination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to the causa(s) and mannar stated. Medical 29a. Certifier (Check only one) 29b. Signatura end titla of certal 29c. License number 29d. Data signed (Month, Dey, Year) d address of parson who Middleton of death (Item 23a) (Type, Print) 68 8 Tool toad 32. Ragistrar's Signature 31. Data filed (Month, Day, Year) State APR 2 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

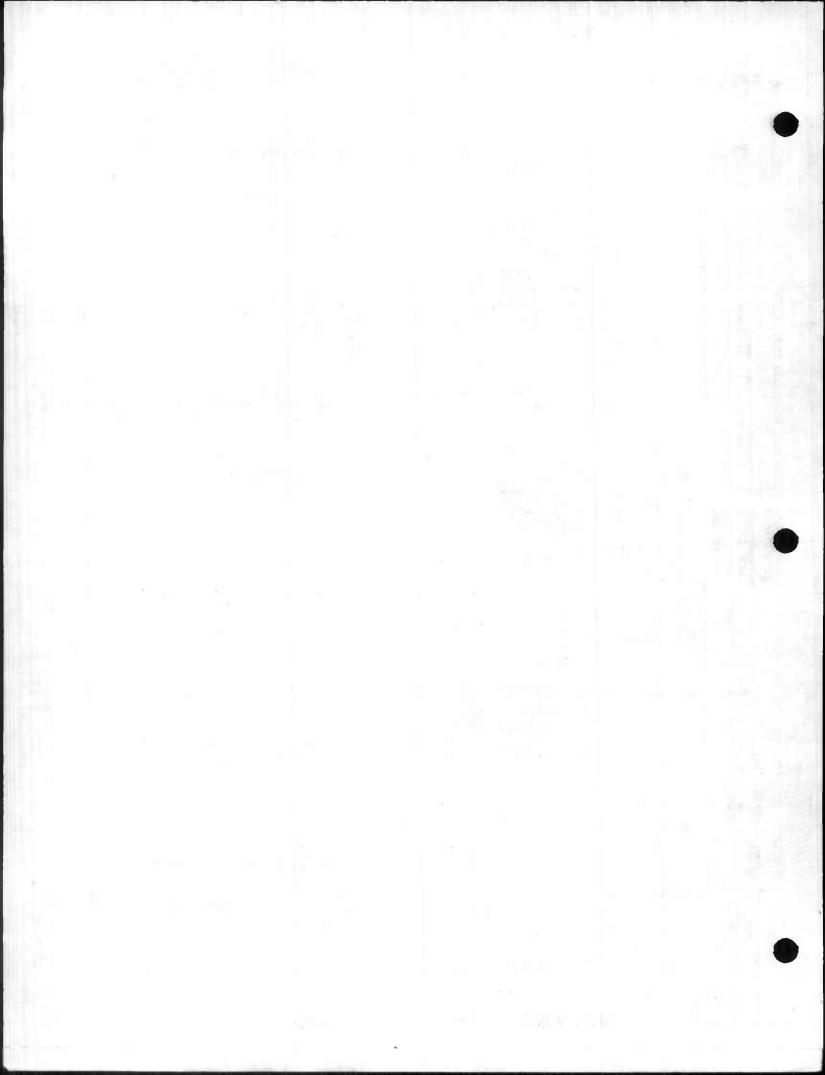
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Tima of Death Month 50 **Physician** THERESA CLIFTON MILLS /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthpiace (State or Foreign **Funeral** Months 1□ M 21 F Deys 76 212-20-3355 Director 1922 MARYLAND Usuet Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits WESTMINSTER CARROLL 1X Yes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 8 234 197 EAST MAIN ST. 21157 USA. Funeral 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Bieck, Whita, etc. Peges 1 and 2 should be filed within 72 hours after and of Heelth and Mental hygiena.
Int: if item 27 is marked other than "natural", or item iny or other traumide avent, its leader. 1 Yes 20 No 1 Never Married 2 Married 1 ☐ Yes XONo Specify: Specify: WHITE by 3 ₩idowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 LIBRARIAN GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 JOSEPH H. FARRALL CAROLINE M. DECK 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 2 1 1 5 8 19a. tnformant's Neme/Reletionship (Type, Print) VERA C. FOGLESONG-DAUGHTER 2704 ROBERT Arthur RD., WESTMINSTER, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) important: If It any injury or Department 4/28/99 BALTIMORE, MD. METRO CREMATORY 22. Name and Address of Facility FLETCHER FUNERAL HOME 21. Signature of Funerel Service Licensee 254 E. MAIN ST., WESTMINSTER, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause as each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 36 HOURS INTRACEREBEAL HEMORRHAGE Examiner MASSIVE Due to (or as a consequence of): Examiner HUDERTENSIVE CARDIOVASCULAR VERRS Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) physicien at the buriel Physician/Medical Due to (or as e consequence of): signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to completion of causa of death? Completed 24a. Wes an autopsy performed? 1 Yas 1 ☐ Yes 2 ☐ No Attanding Physician: 25. Was case referred to medical axaminer? 80 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) funerai 27. Mannes of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 T Homicide ŏ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the å ‡ 29b. Signeture and title of certified 29c. License number 29d. Data signed (Month, Day, Year) Do 1662 mo 30. Name and eddress of person who completed cause of death (Nam 23a) (Type, Print) 906C WASHINGTON RD 10000 12 WESTMINSTER MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95

Baitimore, Maryland 21215-0020

#10-10-83



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 305 **HENRY** PRIL 30 MAKER, /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Cecil If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1⊠M 2□ F 79 Director 222-09-3006 September 29,1919 Maryland Usual Residence of Decedent with the Meryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or frama 23a or 28a-f show trsumatic event, the Magical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 United States Funeral 3727 Turkey Point Road death Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 11. Marital Status Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or ite 1 ⊠Yes 2 □ No
If Yes, Give US Army
Year or Dates: 1942 - 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: **Black** Specify: by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Veterans Elementary/Secondary (0-12) College (1-4or 5+) 9 Hospital Center Nursing Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lottie Holland John H. Maker 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19958 John H. Maker, Jr. / Son R.D. 1, Box 264A, Lewes, DE other 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) May 7 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Delaware Veterans Cemetery 1999 Bear, Delaware 21. Signature Funeral Space License 22. Name and Address of Facility Crouch Funeral Home de 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final evere Cardionyoputhy
Due to (or as a consequence of): disease or condition resulting in death) Examiner Examiner Obstructive Palmonary Discuse Chronic that the death certificete be executed physician end the burief-trensit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequenca of): It xpertension Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 88 950 for signed by the e Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 : 1 Yes 2 No 2 1100 1 Yes certificate or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Watural 5 Pending efter deeth. Director: Aft 1 Yes Investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai pletely (Check only one) within 2 To the i To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number MA 0047711 TIVA 30. Name and address or person who completed cause of death (ttem 23a) (Type, Print) DAVID MAULDIN AVENUE NORTH EAST, MARKLAND 6AR-BL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 4 1999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 7:00 A.M May 1999 HAT.I. MANN /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 100 Burgess Way, Apt. 109 Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2☑F 83 Director 108-07-1012 Dec 29, 1915 New York Usuel Residence of Decedent death with the Maryland 10a State ahow 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow 1 Ves 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examinar must be 21701 United States

14. Race - Amarican Indian,
Bleck, White, etc. Funeral 786 D Wembley Drive 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marifal Status Pages 1 and 2 should be Illed within 72 hours after one of Nealth and Mental Hygieno.
and if Item 27 Is marked other than "natural", or ites
any or other traumatic avant, its Medice Essentia 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorcad white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Doctor's Office Medical Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be William Ellen. Hall Stewart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
, Apt. # 109 19a. fnformant's Neme/Relationship (Type, Print) Apt. Lorretta J. Zickefoose / daughter 100 Burgess Way/ Frederick, MD 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cramation 3 ☐ Removel from Stete Department 4 ☐ Donetion 5 ☐ Other (Specify) Cairo Cemetery 5/7/99 Cairo, Ohio 22. Name end Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximete Interval Between **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 10/2 YEARS METACTATIC RECTAL CANCER Examiner Due to (or es e consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 ahould 1 ☐ Yes 2 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home \$72 Residence 6 Other (Specify) Medical Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Investigation Natural
Accident 1 Yes 2 No death. To the Hospital or Attand within 24 hours after deal To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Cartifiar (Check only one) 296, Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 031761

State Registrar 501 W. SEVENTH ST. FREDERICK MD

30. Name and eddress of parson who completed cause of death (Item 23a) (Type, Print)

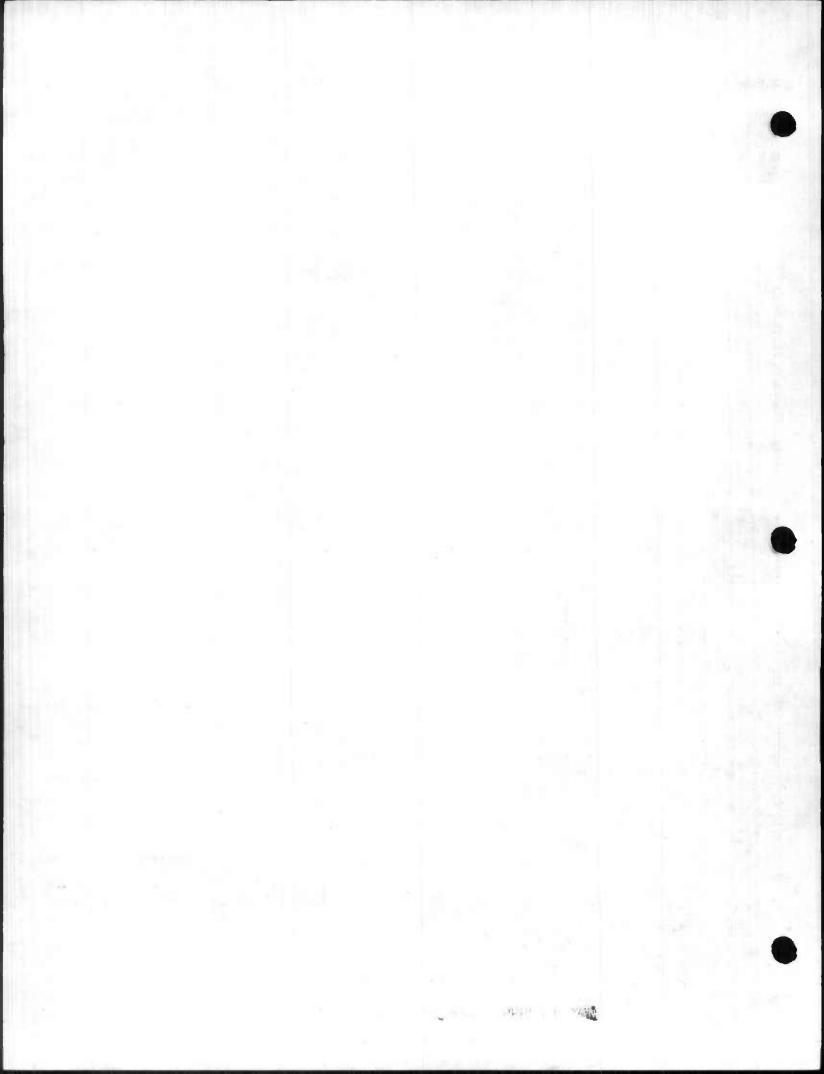
0 4 1999

BRIAN M. O'CONNAR

31. Deta filed (Month, Day, Year)

MD

32. Registrar Signature

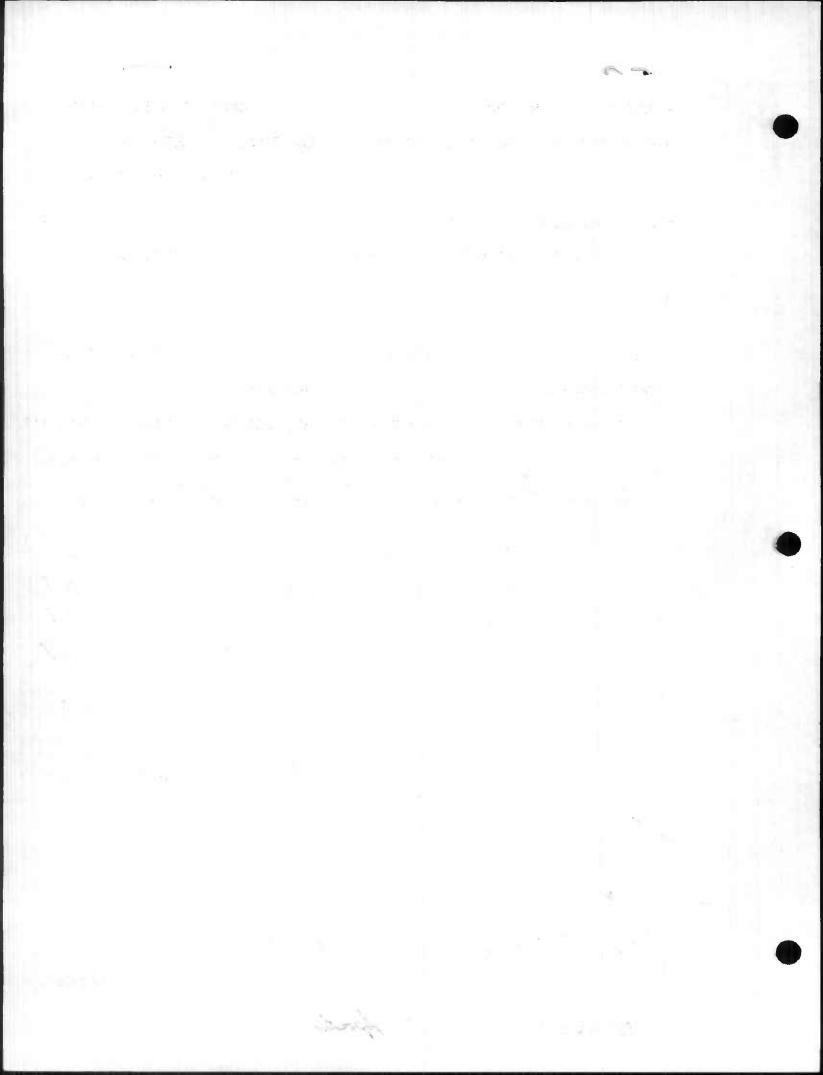


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/Medic		4a. Facility Nema (If not institution, giva				4b. City, Town, o	or Location of Deat			0300
LAdilli	iei	MARINER HEALTH &		GLEN BUR	- AS - 1	GLEN BU				EL COUNT
Funeral Director		5. Social Sacurity Number 6. Se 577-03-0344	7. Aga	(In yrs. last birthday	1 44 44 4 7 7		rs. 8. Data of Bir			ace (State or Fore
M 12		Usual Residence of Decedant 10a. Steta 10b. County	1	10c. City, Town or I	ocation				10	d. Inside City Llm
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noti	Director	10e. Street and Number	ON	TALLE OIL	10f. Zip Coda			10g. Citizan of W	het Count	ry?
23a o		115 KINGS HIGHWAY	, UNIT #44	0	08052			UNITED	STATI	ES
at', or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Navar Marriad 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorcad	12. Was Decedant Ev Armed Forces? 1 ☐ Yas 2∑ No If Yas, Giva Yaar or Datas:	var in U,S. 13	Was Dacedant of H If Yes, specify Cub		(Specify Yas or No erto Rican, atc.)	14. Raca Black Specify:	- America , Whita, a WHIT	tc.
than "natura the Medical E	Completed	15. Decadant's Edu (Specify only highast grad	ucation la complatad) Collega (1-4or 5+)	(Giv lifa.	edant's Usual Occup a kind of work done DO NOT usa retire	pation during most of w d)	vorking	16b. Kind of Bus		
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ked o ked o ic ev	To Be	HERMAN CHICHESTER				(UNKNO		,	7	
mari umat	-	19a. Informant's Name/Relationship (7)		19b. Mal	ling Addrass (Streat			er, City or Town, S	Stata, Zip (Code)
27 la		ANTOINETTE COOK,	DAUGHTER		KINGS HIG					
ent of He st: if Bern ry or othe		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Ramoval from State	20b. Place of Disp camatary, cri		ca)	Data 4/27/99	20c. Location - C	City or Tow	
Departm Importar any injur 9005		21. Signature of Funeral Sarvica Licans		2	22. Nama end Addra FORT LINC	iss of Facility			ЮБ, 1	MAKILANI
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ysician		23a. Pert1. Enjer tha disaasa, or compl shock, or haart failure. List only o	ications that caused the na causa on each lina.	Do not a	nter the moda of dyli	ng, such as card	iec or raspiratory a	rrest,		Approximeta Intarval Between Onset end Death
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siciar buria		cause. Entar UndarlyIng Causa (Disaase or Injury that Initieted avants	· MAS	77476	1				/	///
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W 0	Phy	Part ii. Other significant conditions cor	tributing to death but i	not rasulting in tha	undanying causa giv	an in Part I.		tobacco usa cont Yes 2□ No	3 Probe	1/
been sign	Completed by		,					an autopsy ermed?	avai	a autopsy finding labia prior to pletion of cause eath?
page 2	E						10	Yas 21 No	1 🗆	Yas 20 No
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rs artar death. al Director: A ed in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide Could not be determined	28a. Place of Injury building, etc. (140 2 2 110	28f. Location (: City or Tou	Street and Number vn, Stata)	r or Rural	Routa Number,
within 24 hours aftar d To the Funeral Direct completaly filled in by	edicai	29a. Certifier (Check only one) Cartifying Physical Examile (Check only one)	sician: To the best of n ner: On the besis of ex and manner states	caminetion and/or li	th occurred at the tirnvestigation, in my o	me, dete and pla pinlon, death oc	ca, and due to tha currad at tha time,	causa(s) end men dete end placa, er	nar as ste	ted. the ceusa(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death Day 1999 **Physician** Month JAMES THOMAS MATHEWS JR. APR 25 5:15 AM /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) South 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□ F Days Yes Director 251-64-3874 83 Nov. 15, 1915 Usual Residence of Decedent Carolina 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Nems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at Virginia Arlington 1 Yas 2 No Director Arlington 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 3801 North Ridgeview Road 22207 Funeral U.S.A. 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, atc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "naturel", or ther eny Injury or other traumetic event, the Medical Exercise. 1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Captain U. S. Navy 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumame) Be P James Thomas Mathews, Sr. Isabelle Bradham 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3801 North Ridgeview Road, Arlington, Virginia Gladius D. Mathews 20b. Place of Disposition (Name of cemetery, crematory or other place) May 12, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State Arlington National Cem. Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 1999 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility leans Demaine Funeral Homes, INc. 23a. Pert1. Entar tha disaasa, or compilcetions that caused tha death. Do not enter the moda of dying, such as cardiac or respiratory arrest,

Approximata

Approximata Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Final disaase or condition rasulting In death) PNEUMONIA Examine Due to (or as a consequence of) attending physician and I for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 ₺ inpatient 2 □ ER/Outpatient 3 □ DOA funeral 27. Manner of Death 28c. Injury et Work? 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 1 XNatural 5 Pending To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifle 29c. License number **RES-000** 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER SHARON B. REED, LT, MC, USN BETHESDA MD 20889-5600

State Registrar

31. Dete filed (Month, Dey, Yeer) APR 2 8 1999 32. Registrar's Signatura

deeth with the Maryland

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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After this

Attending Physician:

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	23a d	aic	9900 Wallertown	n Road			2183	7		U.S.A	7	
020	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23s or 28s-f show svent, the Modical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			/as Decedent of Yes, specify Cu ☐ Yes 2 No.		(Specify Yes or Nuerto Rican, etc.)	lo- 14. Rad Bie Specif	ce - Americok, White,	etc.
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Baltimore,	permit. Pages 1 a Department of Hec Important: If frem any Injury or othe		20e. Method of Disposition 1 Burial 2 Cremetion 3 F 4 Donetion 5 Other (Specify)				ition (Neme of etory or other p		5/1/99	Vienna		
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death **Month** CHARLES MOSLEY WILLIAM April 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1X M 2□ F 66 AUG. 17,1932 220-28-0909 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MARYLAND WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 311 CAREY AVE. U.S.A. 21804 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Marital Stetus 1 ☐ Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Year or Detes: 1 ☐ Yes 2 K No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decadent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) GASOLINE PUMP CO. ENGINEER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **CHARLES** MOSLEY EDWARD ANNIE MARY CAMPBELL 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1404 PROCTERS PURCHASE RD.

Obstructive lung Visease

20b. Place of Disposition (Name of cemetery, crematory or other place)

F5P 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

WICOMICO MEMORIAL PARK

22. Neme end Address of Facility

HARTLEY, DE 19953

SALISBURY, MD 21804

Approximate Interval Between Onset and Death

20c. Location - City or Town, State

4/27/99 SALISBURY, MARYLAND

705 E. MAIN ST.

Physician /Medical

Physician

Examiner

Funeral

Director

28a-1 show

Itams 23a

"natural", or

should be filed within 7 and Mental Hygiene.

eges 1 end 2 should be fill ont of Health end Mental H t: if flem 27 is marked oth

other

à Depertment of Important: If any injury or

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

Funeral

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Completed

/Medical

10a. State

Examiner

attending p signed by t cete has t director. After Director: / To the Hospital o within 24 hours eff To the Funaral Di completely filled in

Examiner physician end s the burial-transit Physician/Medical Completed by or Attending Physician: Be 2 Certification:

104 /JR

Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequenca of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Chronic Bromehites 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturei 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edlcai 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) APR 2 7 1999

30. Name and address of passon who complete

BONNIE_L. WOOD - DAUGHTER

4 ☐ Donation 5 ☐ Other (Specify)

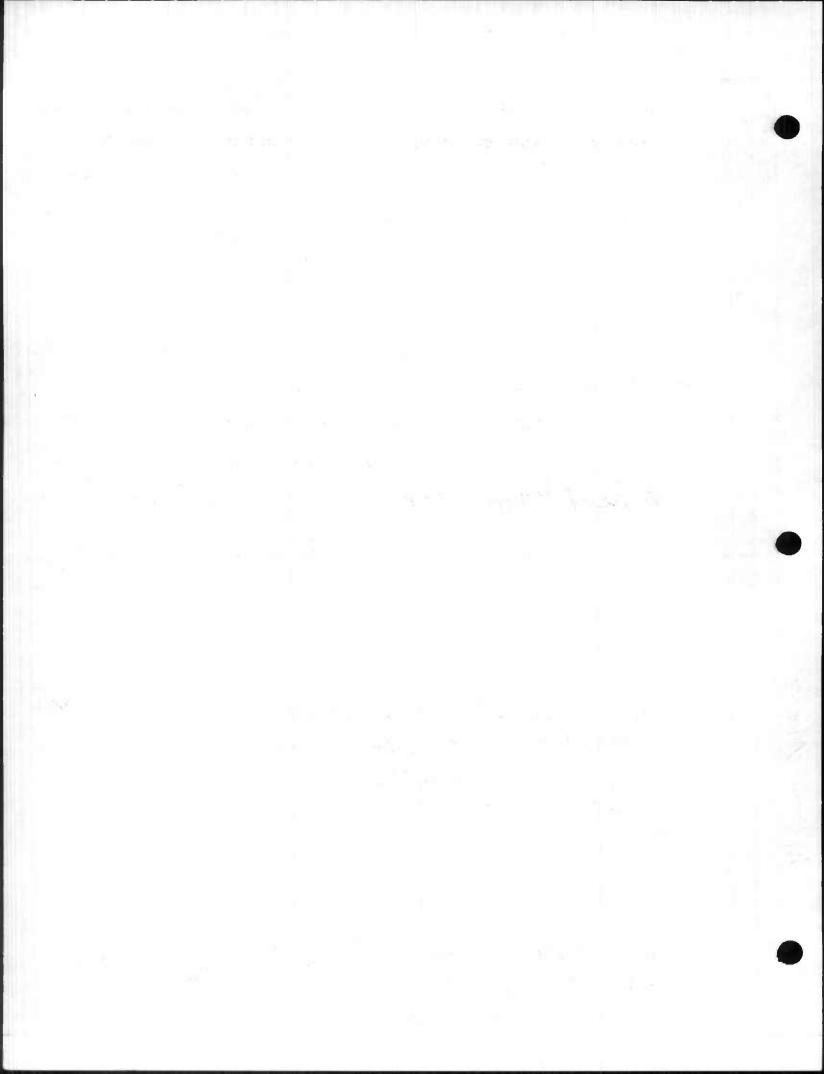
1 N Burial 2 □ Cremation 3 □ Removal from State

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

> Evan 32. Figistrar's Signeture

team (Ilem 23a) (Type, Print)

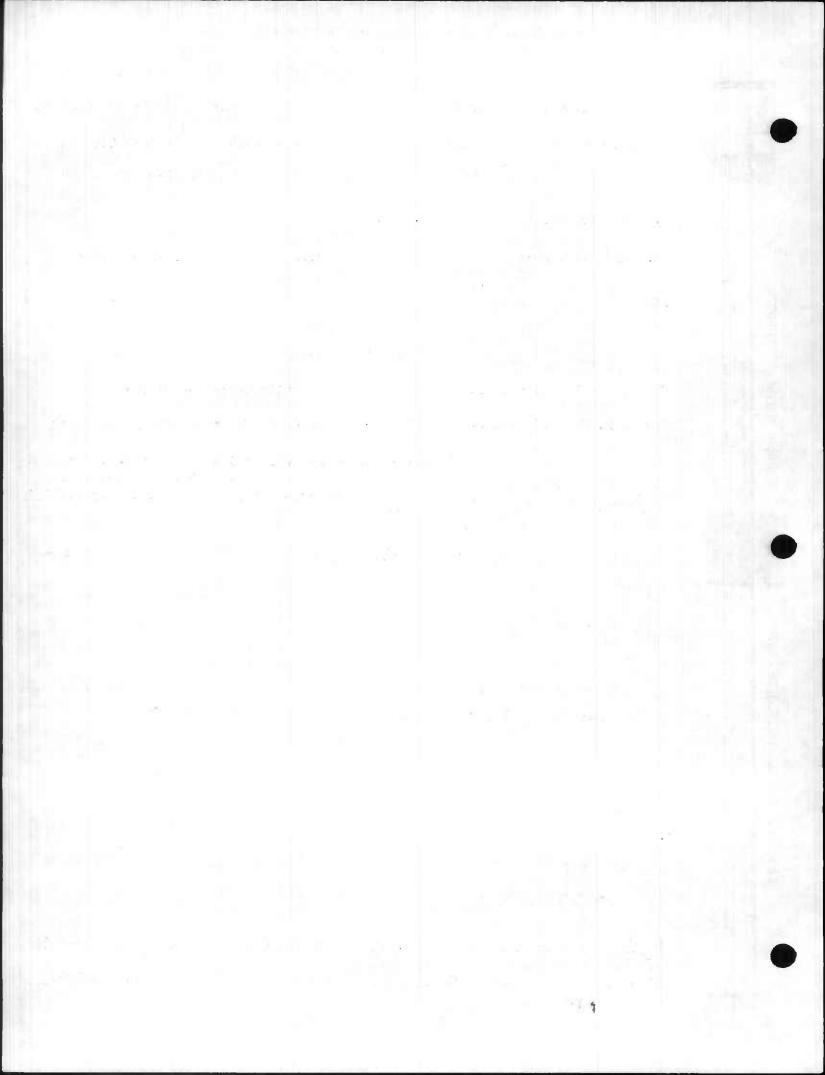


Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 2, 1999 0205 AM May RUTH KATHERINE MASSER /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Takoma Park Washington Adventist Hospital Prince Georges If Under 1 Year | If Under 24 Hrs. | 6. Dete of Birth (Month, Dey, Year) 5. Sociei Security Number 7. Age (În yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□ M 2XX Months 82 Yrs. Director 217-10-9406 May 16, 1916 Maryland Usuet Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "naturel; or items 23s or 28s-f show any injury or other traumstic event, the Medical Examinal must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Maryland Frederick Frederick Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8211 Ridgelea Court 21702 United States Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 30XWidowed 4 □ Divorced Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Retail Department Manager 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Lest) Charles Rupley Cline, Sr. Lily Katherine Gladhill 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4939 Tuscarora Road Geneva P. Stunkel, sister Tuscarora, Maryland 21790 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Christ Reformed Cemetery 5/5/99 | Middletown, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signeture of Funeral Service Lightset 1621 Opossumtown Pike Frederick, Maryland 21702 querel Enter the disease, or complications that caused the month. Do not enter the mode of dying, such as cardiac or respiretory errest, or hear feilure. List only one cause on each line Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Aartee Stenou disease or condition resulting in deeth) Examiner Due to (or es e consequence ot) Examiner physician and the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot) P.O. Box 68760, Physician/Medical Due to (or es e consequence ot): for use es t signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy periormed? Completed Is certificate has director, page 2 1 Yes 2€No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice stelly filled in by the funeral director, 1 Be 25. Wes case reterred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2550 2 1 Propatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 ☐ Homicide A 24 hours D Certifier (Check only one)

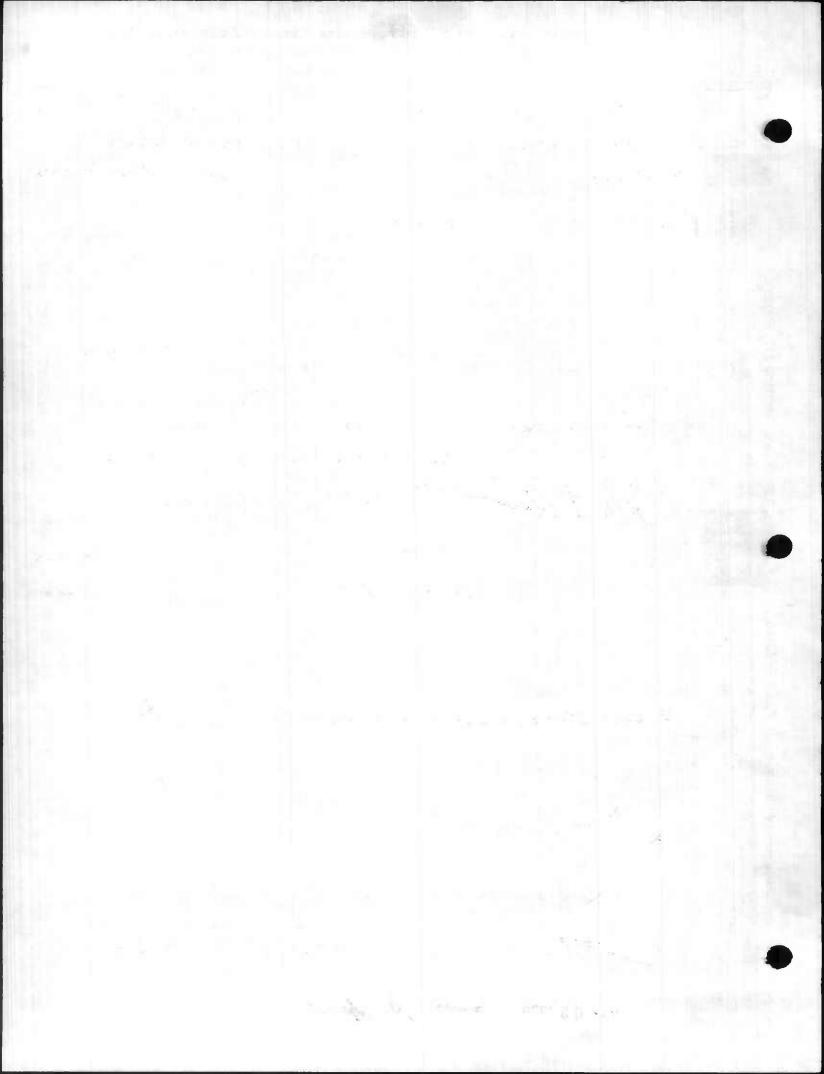
Ce To the Hospi within 24 hour To the Funer completely fil 29a. Certifier edical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 1999 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 7600 Aue 1999 Registra's Signeture State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Directors State Control Contr																	
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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) S. Mathew 11910 HG Truman Road Lusby, Maryland 20657 State 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature		The run	0	1 Natural 5 □ Pe		(Month,	Dey Yeer)		ry				d. Describe	now injury occu	req		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

15542

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	s 1 and 2 should be filed within 72 hours efter death with the Meryland fem 521 fem fem 54 hours of frems 23s or 28s-f show other traumetic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	10e. Street and N	Number				10f. Zip	Code			10g. Citizen of	What Cou	ntry?
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	other tr	SABRINA	A NICHOL	AS-DAUGHT					REET,	LANHAM		2070	
Baltimore,	of He	20a. Method of D		Removal from State	20b. Plac	ce of Disponentery, crea	sition (Nam	ne of ther plac	ce)	Date	20c. Locetion	- City or T	own, State
Ĕ	D → = 0		n 5 ☐ Other (Speci		HAR	MON	MEM	ORI	IAL PK	22-99	LANDO	VER,	MARYLANI
		21. Signeture of	Funeral Service Lice	maga_/		2:	2. Name end	d Addre	ss of Facility				
Ba	pemit. Departr Imports any Inje DDG6.	12	P		- 1					AL HOME			
		//	<u>.</u>	Jayla	91)							WASH	.DC 20001
	-	23a. Pert1. Ente	or the disease, or come eart failure. List only	plicetions that thused one cause on each lin	the death.	Do not en	er the mode	e of dyir	ng, such as cerd	liac or respiretory	errest,		Approximete Interval Between
F	Physician												Onset and Death
	/Medical	Immediate Ceus disease or condi	e (Final	HEPAT	PO_RE	NAT.	CVND	PON	(F			1	1 WEEK
	Examiner	resulting in deeth	h)	a	Due to (or e			KOI	115			1	I WEEK
	ē l			CIRRI				D				- 1	YEARS
	min min			b								1	THAND
_04	certificate be executed rightly physician and use as the burial-transit	Sequentially list if any, leeding to cause. Enter Un Cause (Disease that initiated eve	conditions, immediate	ETHAN	Due to (or a							1	VENDO
9	be iciar	Cause (Disease	or injury	C	NOL E	10031	•					1	YEARS
68760,	at the death certificate be d by the attending physicia eleched for use as the bur Physician/Medical	resulting in death	n) Last		Due to (or a	s a consec	uence of):						
×	ending properties as			d								i	
				G								İ	
. 6	sic ed fo	Part II. Other aig	nificant conditions	contributing to death bu	ıt not resulti	ng in the u	nderlying ca	ause giv	ven in Part i.	23b. Di	d tobacco use co	ontribute t	to the ceues of death?
P.0	requires that the death seen signed by the atter hould be deteched for it eted by Physicial	DI	ADEMEC W	ET T TMUC						X	Yee 2 No	3 Pro	bably 4 Unknown
	igned be del	שונע	ABETES M	EPPILO2						_			
Records,	uires d big									24a. Wa	s an autopsy	24b. W	/ere autopsy findings
Ö	been si should									per	formed?	C	veilable prior to ompletion of cause
e e	8 8 5												deeth?
= 1	ysician: The list certificate he director, pege									10	Yes X No	1	Yes 2 No
of Vital	Physician: The this certificate ral director, pag	25. Was cese ref	ferred to medicel						26. Plece of D	Deeth (Check only	one)		
>	hysic il dire		No No	Hospital: 1 Inpatie	nt 2 EF	R/Outpatie	nt 3 DO	A Oth	ner: 4 Nursing	Home 5□ Re	sidence 6 Ot	her (Speci	ify)
	P P P P P P P P P P P P P P P P P P P	27. Manner of De		28a. Date of Injur (Month, Day	y 2	8b. Time o	f 2	8c. Injui Woi			how injury occu		
Division	tal or Attending P is after deeth. al Director: After t led in by the funers Certification:	1 Netural 2 Accident	5 Pending investigation		roar)	Injury	М		Yes 2 □ No				
S	dee ctor	3 Suicide	6 Could not b	28e. Place of Inju	Jry - At hom	e, farm, st	eet, factory	. office		28f. Location	(Street and Num	ber or Rur	ral Route Number,
S	or Attendi after deeth. Diractor: A i in by the fi ertificati	4 Homicid	e Gereillinec	28e. Place of Inju building, etc	(Specify)		,			City or T	own, State)		
_	To the Hospital or Attending Physician 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: Medical Certification: 7	20a Cartifica	W O with the Di	- Indian To the book				A 45 - A'					
	To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only	2 Medical Exa	nysician: To the best o	examination	n and/or in	occurred a vestigation,	In my o	me, date and pie pinion, death o	ccurred at the time	e cause(s) end m e, date and place	anner as : , and due !	nated. to the cause(s)
	Ted plants	one)		and manner sta	ted.								
	With To the com	29b. Signature	a fittle of certifier	1	200	-	29c	. Licens	se number	71 10	29d. Date sign	ed (Month,	Day, Year)
	2		tere	NZ	gro	NI	0	DO)5885		APRIL	21,	1999
	181	30. Name and ad	idress of person who	completed cause of de	eath (Item 2	3a) (Tyne	Print)						
	(0)		VEN LIPS					AD.	ROCK	VILLE,	MD		
	State	31. Date filed (M	onth, Day, Year)	32. Registra		9							
	Registrar	APR	2 6 1999	Canada	1	1. 10	pork	2/					

Spale

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_				State of Man		rtificate of			eg. No.	15	543
	Physic /Medi		Decedent's Neme (First, Middle, Last Edythe	")	New	nan		2. Dete of Deet Month April 2:	Dey	Year	3. Time of Death 8:30AM
	Examin Funeral Director	ner	243 20 3030	Or. 7. Age (/	n <i>yrs. l</i> es <i>t birthday)</i> 76 Yrs.	If Under 1 Year Months Deys	4b. City, Town, or I Silver S If Under 24 Hrs. Hours Min.			gomery 9. Birtholeo	r e (State or Foreign Carolina
	inyland show		Usuel Residenca of Decedent 10e. Stete 10b. County	10	Oc. City, Town or Lo	ocation				10d.	Inside City Limits
	3a or 28a-f	Funeral Director	Maryland Montgome: 10e. Street end Number 3280 Glen Eagle D		Silver Sp	10f. Zip Code 20906		10	og. Citizen of W	/het Country	1 □ Yes 2 X No
020	within 72 hours effer death with the Maryland iene. Then enture!, or ferms 23a or 28a-f show the Medical Examiner must be indiffed at	by	11. Marital Status 1 Never Married 2 Married 3 WWidowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Bleck	e - American k, White, etc White	
21215-0020		Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	cation e com <i>pleted)</i> College (1-4or 5+)	16e. Dece (Give life.		pation during most of wor d)	king	Own Hom		try
Maryland	S d a S	To Be	17. Father's Neme (First, Middle, Last) Kerney Batchelor				18. Mother's Nan	ne (First, Middle, N Davis	feiden Sumem	e)	
Man	nd 2 should th end Mer 27 is marke traumatic		19e. Informent's Neme/Reletionship (T) Gary Newman—Son	rpe, Print)			end Number or Ru				ide)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra QDCS.		20e. Method of Disposition 1 M Burlel 2 Cremetlon 3 F 4 Donetion 5 Other (Specify)	Removal from State	20b. Plece of Dispo cemetery, crer	sition (Neme of netory or other ple		Dete 2	20c. Location -	City or Town	
Balti	permit. Departminents Imports any inju		21. Signature of Funeral Service License	elos)			ess of Facility Ler's Son		130 Wis	sconsi	n Ave.
x 68760,	ettending physician and ifor use as the buriet-transit	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last	Due	a to (or es e consecuent of to (or es a cons	uence of):	Infa	rction		m	inutes
P.O. Box	0 0 2	Physician/M	Pert II. Other algnificant conditions cor				ven in Pert I.			tribute to th	e cause of death
Vital Records, I	requires been sign should be	Completed by F	Atrial Fibri	lation,	Chroni	c Obst	roctive	24a. Wes er perform	n eutopsy	24b. Were availa	autopsy findings ble prior to letion of cause
al Re	: The law cate has b	-	0 1) isease				1 □ Ye	s 2 No	1 🗆 Y	
of	Attending Physician: Thir death. sctor: After this certificate by the funeral director, par	ation: To Be	25. Wes case referred to medical examiner? 1 Yes 2 No F 27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation	dospital: 1 Inpatient 28e. Dete of Injury (Month, Dey Ye	2 ER/Outpetier 28b. Time of Injury	28c. Inju	ner: 4□ Nursing H	ome 5 Resider 28d. Describe ho	nca 6 🗆 Othe		
Division	5 5 5 S	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury building, etc. (S	At home, ferm, str Specify)	eet, fectory, offica		28f. Location (Str City or Town		er of Rural R	oute Number,
	To the Hospital within 24 hours of the Funeral completely filled	l edicai	(Check only 2 Medical Examinate)	elclan: To the best of m ner: On the basis of exe end menner steted	aminetion end/or inv	estigetion, in my o	opinion, deeth occu	, end due to the ce rred et the time, de	use(s) end mer te end plece, e	nner es stete and due to the	d. a ceuse(s)
	To the To the comple	M	29b. Signeture end title of cartifier		2 mn	29c. Licens	3202	A	oril 2	3.19	7, Year)
(10)		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	Print) 3305	North	Leism		راط ا	31179
Г	Sta Registr		31. Date filed (Month, Day, Year) APR 2 8 1999	82. Registrer's		/	Sprin	9 1.0	1 y can	4 4	2106

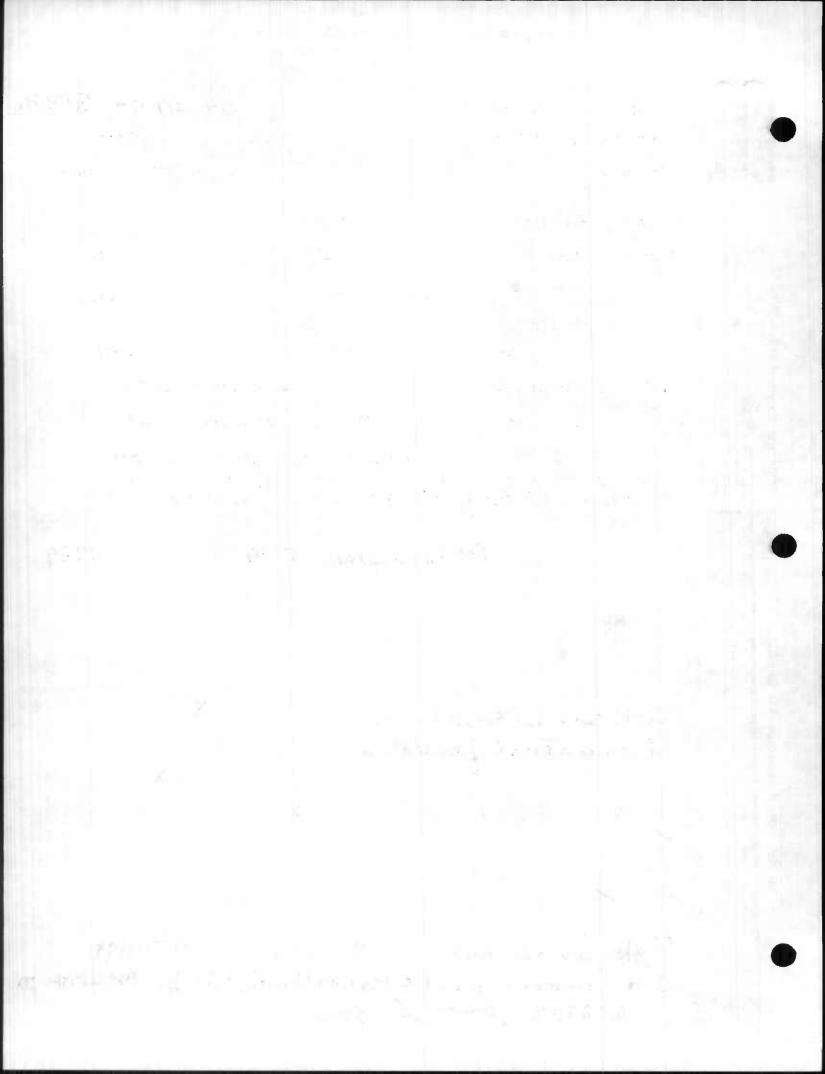
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State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 **Physician** 8:30 FM 04 LeRoy Hugh Olander, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Round Spring Rest Home Union Bridge Carrol1 If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthpleca (Stete or Foreign Country) 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 10XM 2□ F 69 529-26-9437 Yrs. Montana 8, Director Usuai Residence of Decedent the Marylend permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show says fujury or other traumstic event, the Wedical Examiner must be notified an once. 10a Stata 10b. County 10c. City, Town or Location 10d foside City Limits 1 N Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1223 Dahlia Lane 21703 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Giva Yaar or Dates: 1962-84 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Biack, Whita, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0020 1 Tyes 2K No Specify: by White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) 5+ Elementery/Secondery (0-12) military career army 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) LeRoy Hugh Olander, Sr. Lillian Ruth Benedict 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick, MD 21703 Kenneth C. Olander/son 1223 Dahlia Lane 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Namoval from State Arlington National Cem. 5/5/99 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home e ot Funeral Servica Licenses Union Bridge, MD 21791 Jarune 6 E. Broadway 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicat Due to (or as a consequence ot): Examiner Physician/Medical Examiner physician and the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. Due to (or as a consequence of): 98 1 USB 23b. Did tobacco use contributa to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2□ No 3 Probably 4 Unknown Sick Sinis Syndrome signed t Division of Vital Records. by 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Chronic atrial phrillation certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attanding Physician: Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yas No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerei 28a. Date of Injury (Month, Dey Year) 28c. tnjury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation Watural n 24 hours after deeth.

Funeral Director: After details filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated. 29a. Certifier edicai To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, and dua to the cause(s) end menner steted. (Check only one) 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier ancoh and address of person who completed cause of deeth (Item 23a) (Type, Print) ARICARE mi 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State APR 2 9 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death **Physician** MINNIE L. OSBORNE April 24 1999 6:25PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Data of Birth (Month Day, Year) 21 5. Social Security Number Birthplace (State or Foraign Country) 6. Sax Sax X .7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Min 78 Director 30 9082 Washington DC Usual Rasidence of Decede Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiena.

Int: If Item 27 is marked other than "natural; or Items 23s or 28s-f show ary or other traumetic event, the Medical Examiner must be not lifed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Washington D.C. 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20017 U.S.A. 624 #202 Girard Street N.E. Funeral 14. Race - American Indian, 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12th Food Service Fed Gov't 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) William Scott Margret Baylor 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Ruth G. Mitchel Sister Girard St., N.E. #202 624 Washington D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata permit. Pages Department of Important: If It any injury or conce. ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 4/29/99 Washington, D.C. 21. Signatura of Coneral Service Licensee Robert A. Smith 22. Name and Address of Facility
HALL BROTHERS FUNERAL HOME Robert A. Smith

621 Fla. Ave., N.W., Washington, D.C.
23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical SEPSIS ~ 24 dys Examiner Due to (or as a consequence of): Examiner RESPIRATORY

Dua to (or as a consequence of): FAILURE physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): attending p signed by the a d be detached t 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed s cartificate has t 1 Yas 2 No 1 □ Yas 2 □ No Hospital or Attending Physician: 24 hours eftar death. Funeral Director: After this cartifice funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital or J within 24 hours efter To the Funeral Dire completaly filled in the 1 (A Certifying Physician: To the best of my knowladga, daath occurred at tha tima, date end piece, and due to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the ceuse(s) end menner stated. 29a. Cartifian edical 29b. Signatura and titla of cartifier 29d. Date signed (Month, Day, Year) 29c. Licanse number 0-17874 · CNO 30. Name and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print) COTTAGE CITY, MD 20722 S. M. NAMAR 3717-38 'AVE 31. Data filed (Month, Day, Year) APR 2 7 1999 32. Registrar's Signature

DHMH 16 Rav 6/95

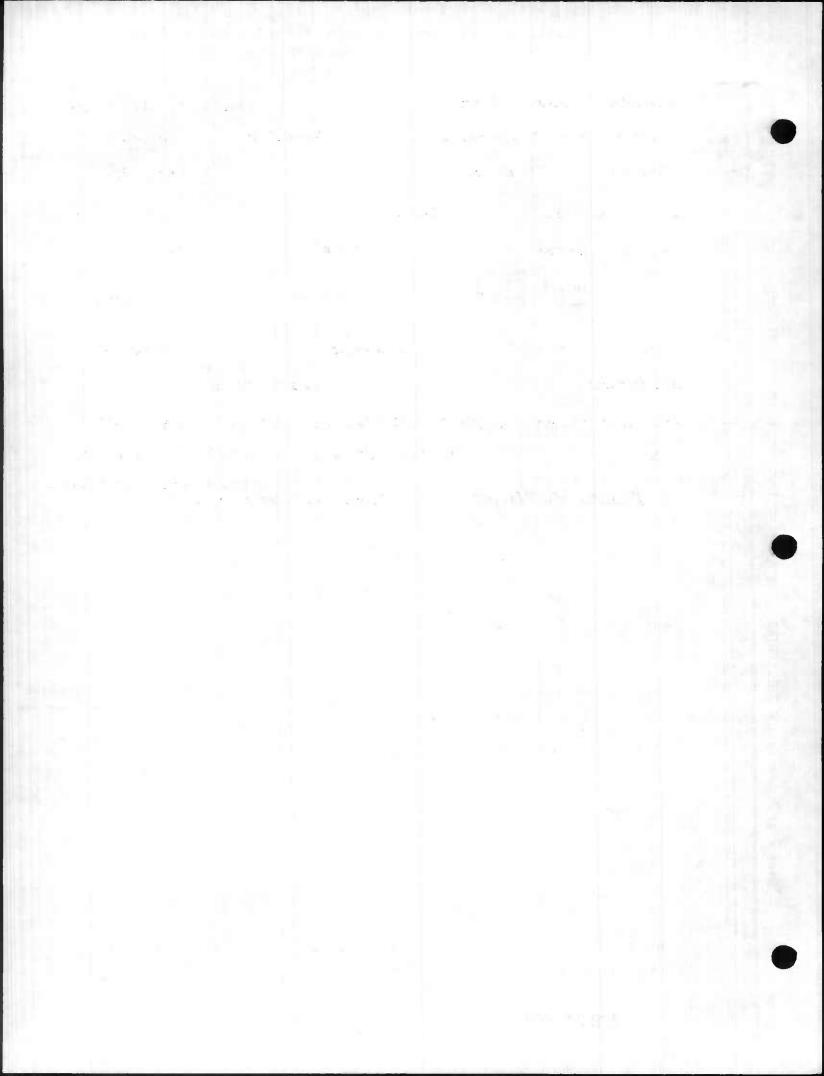
State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician										Reg. No.			
/Medical	1. Decedent's Name (First, Middle, Last) Josephine Olive Plumb								Month Dev Year			3. Time of Death 6:45am	
Examiner		(If not institution, gi m Care		mber) cesville	9		4b. City, To Sykes		ecation of Death	4c. County			
Funeral Director	5. Social Security 234–68–6	642	Sex 1□M 2∏ F	7. Age (In yrs. 90	last birthday, Yrs.	If Under 1 Ye Months Dev		24 Hrs. Min.	8. Dete of Birt (Month, Day May 7	1908	9. Birthpla Countr	ce (State or Foreig y)	
Dus	Usual Residence	of Decedent 10b. County		10c. Cit	y, Town or L	ocation					100	1. Inside City Limit	
sa-faho oprada	Md	Carrol	L		kesvi	lle						Yes 2□N	
filed within 72 hours after deeth with the Maryland ther then *natural*, or items 23a or 28a-f ahow int, the Medical Exercises must be notified at a Completed by Funeral Director	7309 Sec	ond Avenu	ae			10f. Zip Code 2178				10g. Citizen of What Country? USA			
or tems		rried 2 Married	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2⊠ No ve	,S. 13.	Was Decedent of If Yes, specify C	uban, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)	Blac	e - Amarica ck, White, et "White	c.	
eal E		15. Decedent's E	ducation	0100.	16a. Dece	edent's Usual Occ	cupation			16b. Kind of B	ısiness/îndu	stry	
ygiene. nr than "natura t, the Medical Completed	Elementery/Sec	condary (0-12)	rade com <i>pleted)</i> College (1-4or 5+)	-	kind of work do DO NOT use ret omemaker	ne during mos ired)	st of work	domestic				
end Mental Hygiene. Is marked other than aumatic event, the M	8 17. Father'a Name (First, Middle, Last) John Tichmell 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street end Number or Rural Route N									10)			
end : ealth n 27 in 27 in er tr	Mrs. Shirley Hunter (Daughter) 5411 Cabbage Spring Road Mt. Airy,												
												n, State	
		5 Uother (Specifuneral Service Lice	*	4	2	2. Name end Ad	dress of Facil	ity Ha	ight Fu	neral Ho			
d by the attending physician and detached for use as the buriel-trensit detached for use as the	Immediate Ceuse disease or condit resulting in death, Sequentially list of any, leading to cause. Enler Unc Cause (Disease of that Initiated even resulting in death)	conditions, immediate derlying or Injury	a. D. Cu	Due to (c)	or as a conse 1 - O or as a conse or as a conse	equence of):	Mce					Onset and Death	
ine iaw requires man me geam ate hes been signed by the atte page 2 should be detached for completed by Physicial	Part II. Other sign	ificant conditions			-				23b. Did tobacco use contribute to the cau				
been signe should be d	117	J. +	to oe	min	, 2)ene	nhi	0		an autopsy med?	evei	e eutopsy finding lable prior to pletion of cause eath?	
omo									10	res 2000	10	Yes 2□ No	
ctor, p	25. Was case refe	erred to medical					26. Plac	e of Deat	h (Check only o	one)			
this certificate hes ral director, page 2 : To Be Comp	examiner?					III JUDA			**	dence 6 Oth			
this call dire	27. Manner of Deeth 1 Defural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 2 Accident Investigation 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office								28d. Describe I	now injury occur			
rer death. Inactor: After this c in by the funeral dir Tiffication: To	2 Accident	Investigation	200. PIECE	of Injury - At hing, etc. (Specif	ome, farm, s ý)	treet, factory, offi	ce		28f. Location (S City or Tox	Street end Num l vn, State)	per or Rural	Route Number,	
24 hours after death. Funeral Director: After this of step filled in by the funeral director of the f	2 ☐ Accident 3 ☐ Suicide	Investigation	hysician: To the	best of my knoasls of examina	y) wledge, dee	th occurred et the	time, date e	nd placa,	City or To	vn, State) cause(s) and ma	anner es ste	ted.	
within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not leadermined 1 Certifying P 2 Medical Example	hysician: To the	best of my kno	y) wledge, dee	th occurred et the	time, date e	nd placa,	City or To	vn, State) cause(s) and ma	anner es ste and due to	ted. he cause(s)	
lo the hospital or Artending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director, Medical Certification; To Be (2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signature an	Investigation of Could not I determined the Certifying P 2 Medical Example of Certifier the Council of Certifier the Certifier t	hysician: To the miner: On the band man	best of my knoasls of examina ner stated.	wiedge, dee	th occurred et the hvestigation, in m 29c. Lic. , Print)	e time, date e y oplnion, de	nd placa, ath occurr	and due to the red at the time,	vn, State) cause(s) and made end pleca,	anner es ste and due to d (Month, D	ted. he cause(s) ay, Year)	

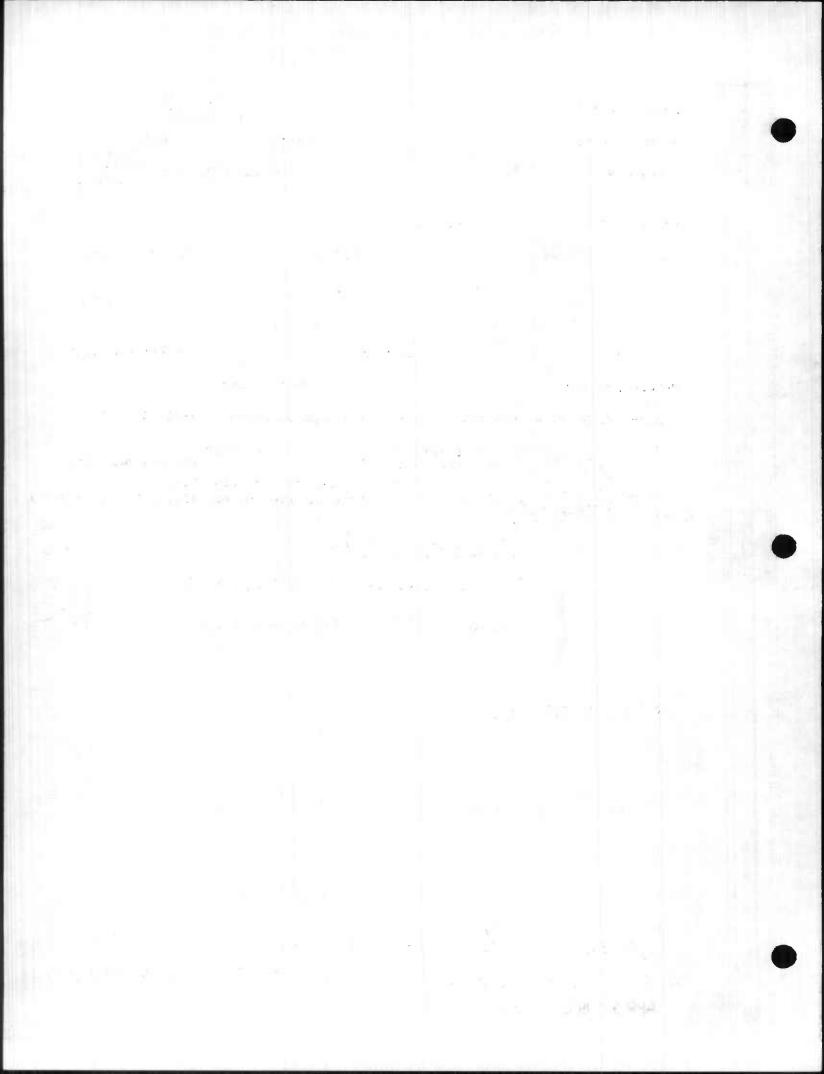


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	Physicia		Roberta Per	kins							APRI/	Day	Year 1995	1503
	/Medic Examin		4a Facility Name (If not In		street and nun	nber)			4b. C	ity, Town, or	Location of Death			
	LAUTHI		Union Hospi	tal					E1	kton		Cecil	L	
	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday)	If Under 1 Y		Jnder 24 Hrs ours Min.		h Voor)		laca (Stata or Foreign
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	land w			County		10c. Cit	y, Town or Lo	ocation					1	0d. Insida City Limits
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	With Se of		233 Sycamor	e Road				219	121			United	State	es
	Jeeth Jeeth	era	11. Marital Status	7.044	12. Was Dece	dant Evar in U	,S. 13.			nic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Rac	e - Amaric	
21215-0020	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mantel Hygiena. It of Health and Mantel Hygiena. If frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, are Medical Examiner must be notified at	by Funeral Director	1 Never Married 2		Armed For 1 Tes If Yes, Giv Yaar or Da	2 ☐No e		If Yes, specify 1 ☐ Yes 2 ☐			to Rican, etc.)	Specify Specify	ck, White, y: Wh	etc. ite
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lan	id be entel ked i	To B	Robert DeGu	erre					T	empa E	Eller			
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N N	Atte	Iffe	3 ☐ Sulcida 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - At h	ome, farm, st	reet, factory, of	fice		28f. Location (S City or Tox	Street and Num	ber or Run	Il Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	edical				sis of examine					e, and due to the urred at the time,			
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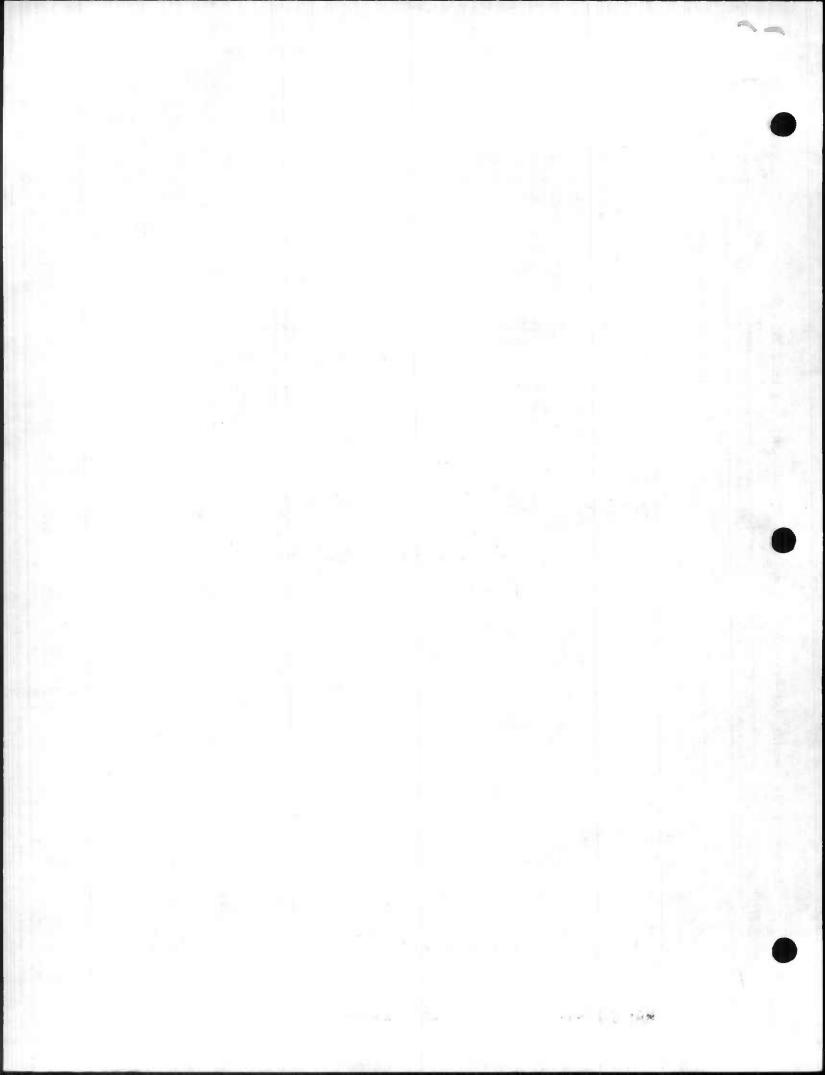
32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

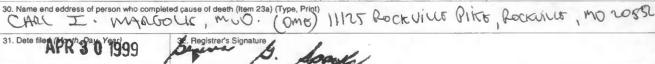
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month PERSAUD 28 ROWA **Physician** SAVITA 1730 1999 APRIL /Medical 4b. City, Town, or Location of Deeth 4a Facility Nema (If not Institution, give street end number) 4c. County of Deeth Examiner TAKOMA PARK WASHINGTON ACCENTIST HOSPITAL MONTGOW BROY If Under 1 Yeer | If Under 24 Hrs. 8. Deta of Birth (Month, Bay, Year) 944 G. Country) Guyana 5. Sociei Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min. 1 M 2 F 578-86-2763 55 Yrs. **Director** Usuel Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yas 2 No PRINCE GEORGES HYATTSVILLE Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be permit. Pages 1 end 2 should be filed within 72 hours efter death v Depentment of Health end Mental Hygiena. Important: If Item 27 is marked other than "naturel", or items 23a any injury or other treumstic event, the Medical Example mean once. 1325 NICHOLSON ST 20782 Funeral UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ENo If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, etc. 11. Merital Stetus 1 Never Married 2 Married GUIANESE Saltimore, Maryland 21215-0020 1 Yes ZONo Spacify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th grade HOME MAKER PRIVATE 18. Mother's Neme (First, Middla, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) TOOLSIE NARAINE BASMATTIE NARAINE 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) KAVITA FREEMAN / DAUGHTER 9025 49th PLACE COLLEGE PARK, MD. 20740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 △ Buriel 2 Cremation 3 Removation State
4 Donation 5 Other (Specify) FT. LÍNCOLN CEMETERY 5/4/99 BRENTWOOD, MD. JOHNSON & JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 716 KENNEDY ST NW WASHINGTON, D.C. 20011 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** ANTENIOSCIPILOTIC CHALDIO UMBCULAR OLIBORE /Medical Immediete Ceuse (Finel disaase or condition resulting in deeth) Examiner Due to (or es e consequence of): Examine physician end the burial-transit law requires that the death certificete be axecuted Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Diseese or Injury Due to (or es a consequence of): Box 68760. Physician/Medical that Initiated events resulting in death) Lest Dua to (or es a consequence of): 80 USe jo signed by the e 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings aveileble prior to compiation of ceusa of deeth? 24e. Wes en eutopsy Completed is certificate has t I director, page 2 s 1 Yes 2 No 1 Yas 28 No Physician: 25. Wes cese referred to medical axaminar? Be 28. Piece of Deeth (Check only one) 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatiant 2 ER/Outpetient 3 DOA this funeral 28d. Dascribe how Injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28h. Time of 28c. Injury et Work? Certification: Aftar Attanding 123 Naturel 5 Pending 1 Yes 2 No death. Investigation ector: / 2 Accident 6 Could not ba determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours efter Funeral Dire letaly filled In b eftar ò Hospital critifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certify To the Hosp within 24 hos To the Fune completaly fi edicai one) 29d. Dete signed (Month, Day, Year) 29b. Signa 29c. License number (DME) April 28, 1999 015236

State Registrar 31. Dete file APR 30 1999



no.

BE DEFIA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** APRIL 29, 1999 HELEN 7:10 am PHILLIPS/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner William Hill Manor Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-22-1900 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K Months Days Hours Yrs. 98 Pennsylvania **Director** 364-68-6822 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a. Stete 10b. County 1 Yes 2 No Directo Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours efter death with till Department of Heelih and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be as page. 501 Dutchman's Lane 21601 US Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Chris Weber Katherine Kauffman 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald Phillips - son 33 North Shore Dr., Seaford, DE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State Capitol Crematory 4/30/99 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Licenses hn A. Cranston Cranston Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. Coronary artery disease

Due to (or es e consequence of): Examiner Examiner hypertrephic cardiomyopathy years physician and the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 80 use ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 2 No 3 Probably 4 Unknown 1 Yes rheumatka polymyalqia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of ... applial or Attendin, in 24 hours after death.

• Funeral Director: After ylely filled in by the ** After Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie 99 D47311 Warne Luce 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

606 Dutchman's Lane, Easton, Md 21601

32. Registrar's Signature

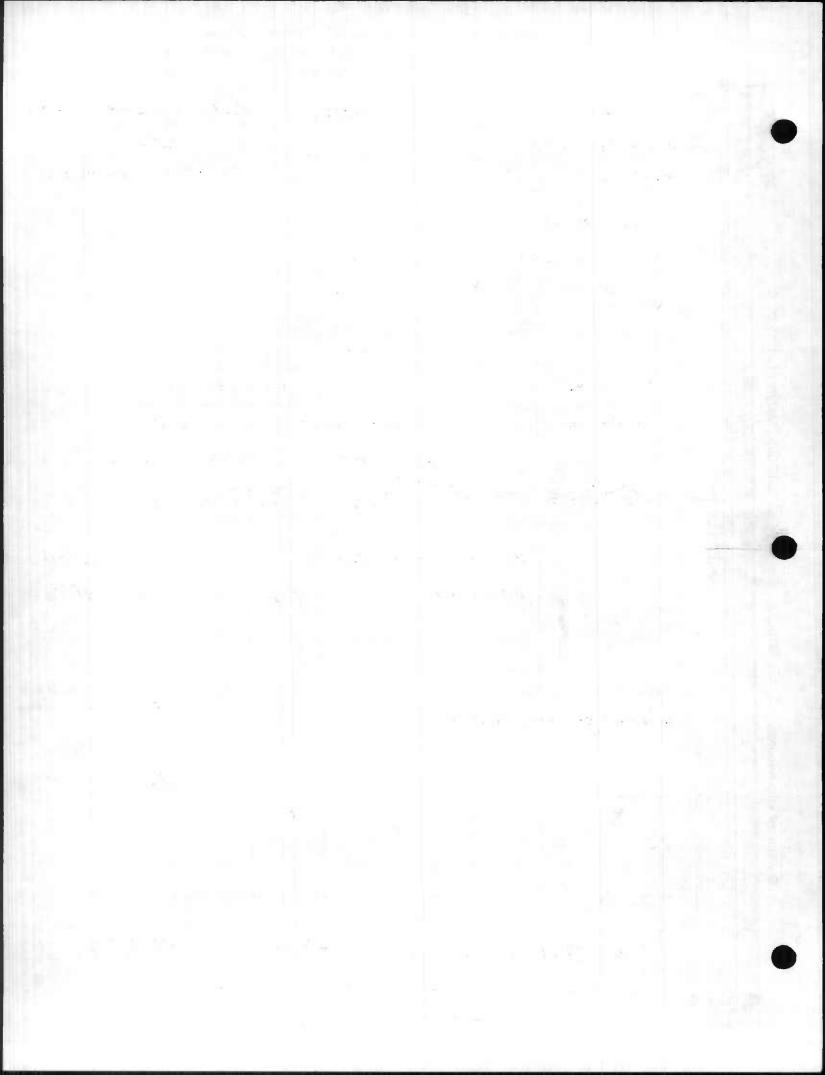
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Registrar

Suzanne Niemela MD

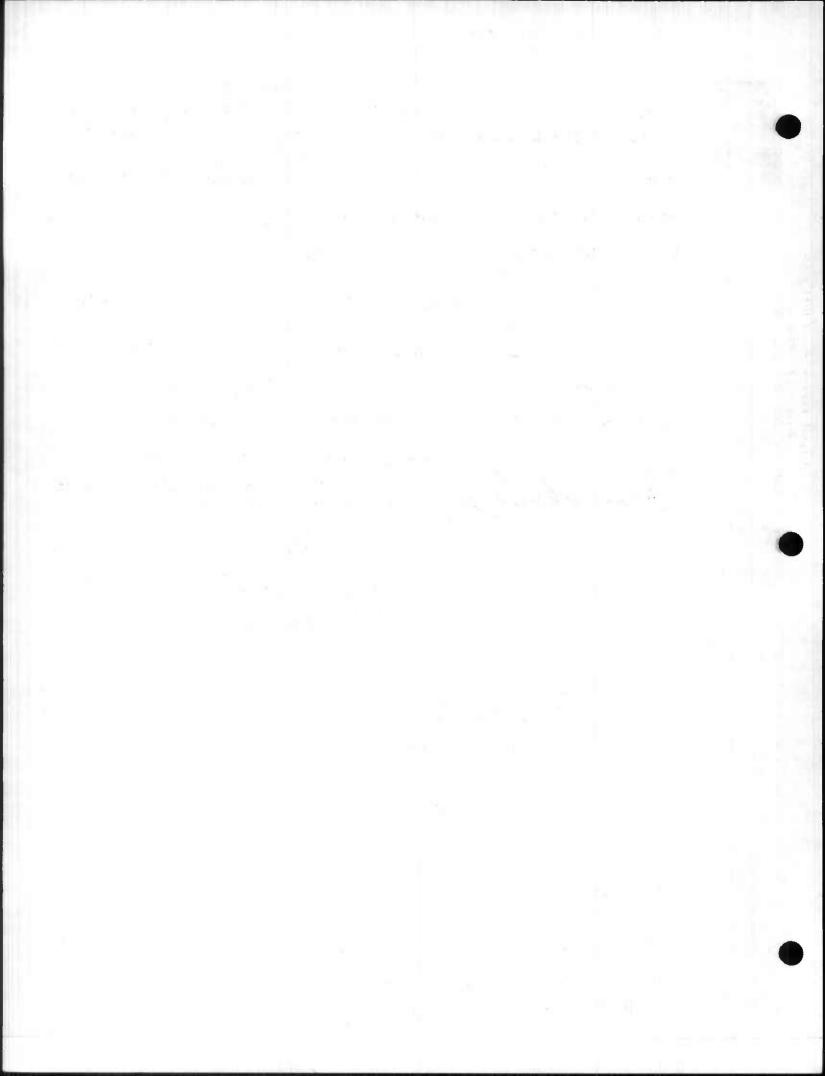
APR 2 9 1999

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 555

				Certificate of	of Death		g. No.	
Physician /Medical	Decedent's Name (First, Middle WILLIAM 4a. Facility Name (If not institution)	F.	P	HIPPIN	4b. City. Town. o	2. Date of Death Month APRIL Location of Death	Day	
Examiner	PENINSULA REGI		CENTER		SALISB			ICOMICO
Funerai Director	5. Social Security Number 214–32–1502 Usual Residence of Decedent	6. Sex 7. Age 1	(In yrs. last birt	hday) If Under 1 Your Months Da				Birthplace (State or Fore Country) Maryland
Mo W	10a. State 10b. County		10c. City, Town					10d. Inside City Lim
r 28a-f show	Maryland Some	rset	Prin	cess Anne				1 ☐ Yes ※ ☐ f
23e or 28a4 s ust be notified rai Director	10e. Street and Number 11887 Tom Nich	ols Rd.		10f. Zip Coo	21853	10	og. Citizen of W USA	fhat Country?
Hygiene. ther than "natural", or items 23s or 28s-1 show but, the Medical Exemples must be notified at completed by Funeral Director	3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 1 Yes 2 □ N if Yes, Give Year or Dates:		13. Was Decedent If Yes, specify (1 ☐ Yes 2 ☒☐	of Hispanic Origin? Cuban, Mexican, Pue No <i>Specify</i> :	(Specify Yes or No- erto Rican, etc.)		- American Indian, k, White, etc. White
natur of all	15. Decedent' (Specify only highest	s Education	18a.	Decedent's Usual Oc (Give kind of work do	cupation	rorkina 1	6b. Kind of Bus	siness/Industry
ygiene. Ner than "naturn nt, the Medical.	Elementary/Secondary (0-12)	College (1-4or 5-	r)	(Give kind of work do life. DO NOT use re			U.S. Po	stal Service
Hygie ther t	12 17. Father's Name (First, Middle, L	ast)	P	ostal Worl		ame (First, Middle, M	feiden Sumema	9)
marked othe umatic event, TO Be C	William James					Catherine		
f Health end Ments tem 27 is marked other traumatic e	19a. Informent's Neme/Relationsh	ip (Type, Print)	19b.	Mailing Address (St	reet and Number or I	Rural Route Number,	City or Town, S	Stete, Zip Code)
Health em 27 i	Barbara L. Phi	ppin/Wife				Rd., Princ	ess Ann	e, MD 21853
Depertment of Hez Important: If Item any injury or othe once.	20a. Method of Disposition 12 Burial Cremation 4 Donattin 5 Dother (Sp	3 □Removal from State	cemetery	Disposition (Name of crematory or other of cemete)	place)	4/26/99		Boury, MD
Depen import any in	21. Signature of Funeral Service L	As legge		501 Snov	Funeral Hill Rd	. Salisbu	rv. MD	l Association 21804
	3a. Part1. Enter the disease, or chock, or heart failure. List of	complications that caused only one cause on each line	the death. Do n	ot enter the mode of	dying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
ysician Medical aminer	Immediate Cause (Final disease or condition resulting in death)	a	your	dial To	farter			Onset and Death How
<u> </u>	, , , , , , , , , , , , , , , , , , , ,	C	Oue to (or es a c		Da :	0,00		15000
in end rial-transit Examiner	Sequentially list conditions	b	Due to (or as a c	onsequence of:	yues O	Dans		Jeans
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disees or injury that initieted events		60	recluded	aflors	Dans		Slays
88 8	resulting in death) Last		oue to (or as a co	onsequence of):	NI (V)			1
or death. ector: After this certificate has been signed by the attending physician end by the funeral director, page 2 should be deteched for use as the burial-tra- iffication: To Be Completed by Physician/Medical Exan		d						
y the oched	Part II. Other significant condition	s contributing to death but	not resulting In	the underlying cause	given in Part I.			tributa to the cause of deat
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should should	C	080	peri N	lead vr	zwen	24a. Was an	autopsy ned?	24b. Were autopsy finding available prior to completion of cause of death?
oage 2		Digens				1 □ Ye	s 2KNo	1 ☐ Yes 2 ☐ No
certificate rector, pag	25. Was case referred to medical examiner?				26. Place of D	eath (Check only one	9)	
this ce all dire	1 ☐ Yes 2 ☐ Nò	Hospital: 1 Inpatien		patient 3L DOA		Home 5 Resider		
After t funera	27. Magner of Death N☐Natural 5 ☐ Pending		Year) 28b. Ti		njury at Work?	28d. Describe ho	w injury occurre	bed
within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	2 Accident investigii 3 Suicide 6 Could not determine	ot bo	ry - At home, fen (Specify)	m, street, factory, off	1 Yes 2 No	28f. Location (Str. City or Town,	eet end Numbe State)	er or Rural Route Number,
within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 CertifyIng (Check only one) 2 Madical E	Phyaician: To the best of xaminar: On the basis of and manner stat	examination and	death occurred et th or Investigation, in n	e time, date end plac ny opinion, death occ	ca, and due to the ce curred at the time, da	use(s) and men te and placa, e	nner as atated. nd due to the cause(s)
To th comp	29b. Signature and title of certifier	(a.)		29c. Lic	ense number	29	d. Date signed	(Month, Day, Year)
	- Custilo 1	(UL W)		DI	6725		U	1201 94
VIVA	30. Name and address of person w	the completed cause of de	ath (Item 23a) (1 - G R		Or, si	lizby.	HD	21801
State	31. Date filed (Month, Day, Yeer)	32. Registra	's Signature	4 /		0		



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** April 27. Dey 1999 Year 8:447 THREASA YVONNE JAMIESON QUARLES /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center La Plata Charles If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min, 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 1□ M 2√2 F Yrs. Director 220-28-6553 69 MARCH 31, 1930 WASHINGTON, DC Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND CHARLES PORT TOBACCO 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7855 PORT TOBACCO 20677 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 □No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2000No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 LICENSED PRACTICAL NURSE MEDICAL. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) HARRIS SAMUEL JAMIESON MARGARET MARY BUSH JAMIESON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20677 19e. Informent's Neme/Relationship (Type, Print) Department of Health a Important: if Item 27 is any injury or other train 905s. JUDY QUARLES / DAUGHTER 7350 CHAPEL POINT RD. P.O. BOX 355 PT. TOBACCO, MD 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) CATHERINE CHURCH CEM 5/1/99 MC CONCHIE, MARYLAND 21. Standard of Funeral Service Licenses

1 ADIA C. THORNTON JOHNSON 22. Name end Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTION ROAD INDIAN HEAD, MD 20640 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Finel . Ischemic Heart discore disease or condition resulting in deeth) Due to (or es e consequença of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thef Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of). Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Chrunic postrictive pulmonary Disense þ Be Completed 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es stated. 25 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner steted. 29b. Signeture end fitte of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) M. Tagorn. yahra D-50883 4-28-99 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) St. Mary's Hospital Dept. of Pathology Yahia M. Tagouri, MD 25500 Pt. Lookout Rd. Leonardtown, Maryland 20650

State Registrar

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Examiner

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To the Hospital within 24 hours a To the Funeral Complately filled

that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

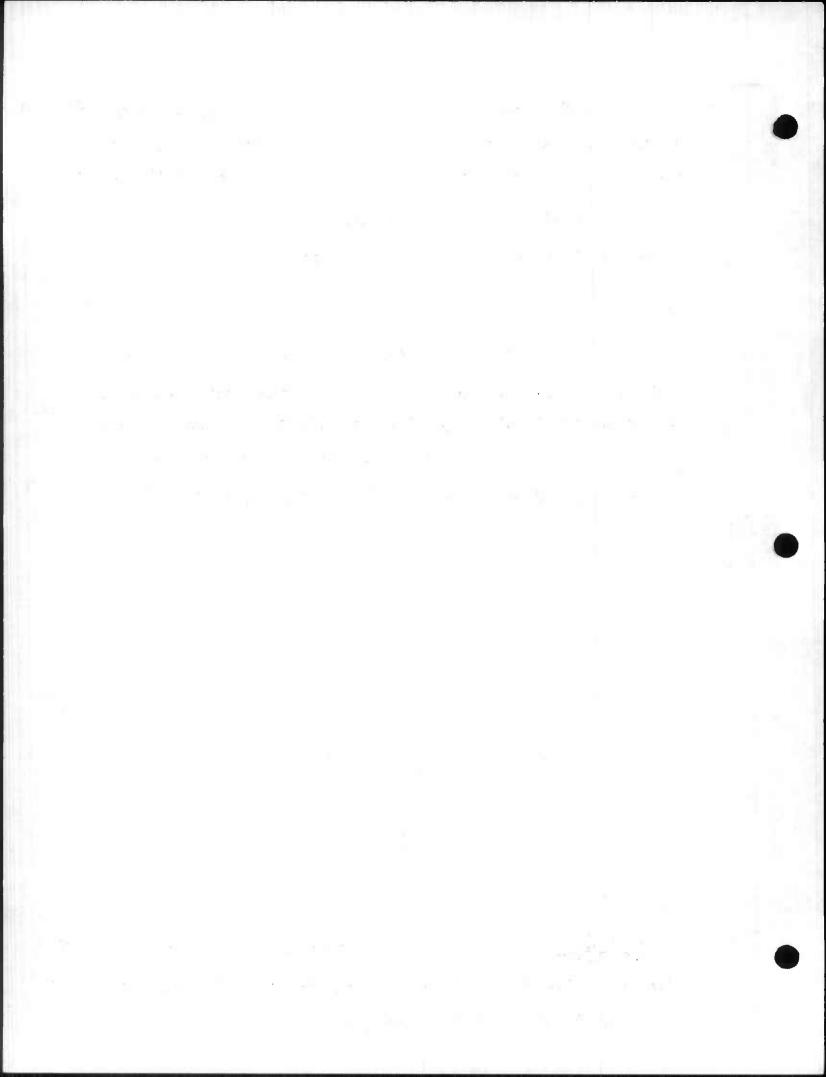
32 Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene O

				Otato of IVI		Certificate of			eg. No.		5553	
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	David St		Fairhaven Life Ca					ville	Carr			
	Funeral Director		5. Social Sacurity Number 6. Se 445–28–7293 Usuel Residence of Decedent		90 (In yrs. last bir	thdey) If Undar 1 Yaar Months Deys		8. Dete of Birth (Month, Dey, Aug 19	, 1908	9. Birthpi Coun Kenti	eca (Stete or Foreigr try) ucky	7
	land w		10e. Stete 10b. County		10c. City, Town	or Location				10	Od. Insida City Limits	
	Mary First eth	to	MD Carroll	L		Sykesvill	e				Y Yes 2□No	
	h the	Director	10e. Street end Number			10f. Zip Code		10	Og. Citizen of V	Vhet Coun	try?	
	th wil		7200 Third Ave	enue			21784		U.S.A.			
20	J within 72 hours after death with the Maryland ilene. Than "natural", or items 23s or 28s-f show if the Marical Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yas 20 N If Yas, Give		13. Wes Decedent of if Yas, specify Cut		pecify Yes or No- o Rican, etc.)	14. Rac	e - Amarica k, Whita, e	etc.	
21215-0020	2 hour		15. Decedent's Edu	Year or Detes:	16a.	Decedent's Usuel Occu	pation		16b. Kind of Bu	islness/Ind	lustry	_
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pu	2 4 5 5	Be (17. Fether's Nema (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	feiden Sumam	Θ)		
Maryland	should be and Mental americal o	70	Alexander Farr		ain		Susa	n Alice	Richa	rdsor	1	
Mai	C) 65 89 6		19a. Informant's Neme/Reletionship (T. Mr. Russell Reno,	,, ,	19b.	Mailing Addrass (Stree	t end Number or Ru	ral Route Number,	City or Town,	Stete, Zip	^{Code)} 21204	
			20e. Method of Disposition	DI. (ACCO.		1800 Mercan Disposition (Name of	cite Brad		INS Pla			_
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other pncs.		1 Burlel 2 XCramation 3 1 4 Donetion 5 Other (Specify,)	cemetar	y, crematory or other pla 11 Crematio	n Serv.					
Bal	Departiment Important Important Incorporation States		21. Signatura of Funeral Service Licens Drican O	X. Aking	et		ass of Facility UNERAL HO le, MD 21				195)	
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ta	an: rtifica	BeC	25. Wes case referred to medical				26. Place of Dea	th (Check only on				
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ion o	nding Pt ath. r: Atter th		27. Mannar of Death 1.2 Naturel 5 Pending 2 Accidant Investigation	28a. Dete of Injur (Month, Day	Year) 28b. T	ime of 28c. Injury Wo	ryat ork?]Yas 2 ☐ No	28d. Dascribe ho	w Injury occur	ed		
Division	if or Atte after der Director d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28a. Plece of Injubuilding, etc	ry - At home, fer . (Specify)	rm, streat, factory, office		28f. Location (St. City or Town		er or Rura	Route Number,	
	To the Hospital or Attending Physician: The is within 24 burs after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifiar (Check only one) 1 Certifying Phy 2 Medicaf Exami	rsician: To the best of inar: On the bests of end manner sta	examinetion end	, death occurred et the t Vor Invastigation, in my	ima, date end placa oplnion, deeth occur	, end due to the ce rred et the time, de	euse(s) and ma ete end plece,	nnar as st end due to	eted. tha ceusa(s)	
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			30. Name and eddress of person who co		eath (Itam 23e) (Type, Print) Liberty	Road	Eldersb	urg 1	d D	21784	
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	Registr	ar	APR 2 8 19	199	neva	B. Spar	Kal					



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Roberts, Jr.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Year

3. Time of Death

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Physician
/Medical
Examiner

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1. Decedent's Name (First, Middle, Last)

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Warren

288-1 ò 23a Barries b "natural".

Baltimore, Maryland 21215-0020 Hygiens. permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: if Item 27 is marked oth. any Injury or other traumatic event ontos.

Physician Examiner

Box 68760

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Records,

Division of Vital

21,30 (4 14,1999 April 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death University of Maryland Hospital If Under 1 Year 9. Birthplace (Stata or Foreign 5. Sociel Security Number 7. Age (In yis. last birthday) **Funeral** 10 M 20 F Months Virginia 579-74-8019 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits MD NO Yes 2 No Dilver Hontaumeru Director 10f. Zio Code 10g. Citizen of What Country? 10e. Streel and Number 20906 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Wes Decedent Ever in U,S. 11 Marital Status Armed Forces' 1 Never Married 2 Merried 1 PYes 2 No If Yes, Give Specify: BLACK 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) College (1-4or 5+) Housekeepuna 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnema) Be W. Roberts, Sr POINTER JUNIOUS JOYCE 19a. fnforment's Name/Relationship (Type, Print) 19b. Melting Address (Street and Number or Rural Route Number, City or Town, Ştete, Zip Code) 10404 GEOrgia ave, Silver Spring, Mo Veronica Sturer- Sister-in-law 20b. Plece of Disposition (Neme of 20e. Mathod of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 D Cremation 3 ☐ Removal from State Riverdale 4.3099 Riverdale, MD Cremeray 4 Donation ,5 ☐ Other (Specify) 22. Nama end Address of Facility BIANCHI FUNDER DELICE Inerel Service Licensea UPSITUR ST NW WASH, DC 20011 23a Pen1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death /Medical Immediate Cause (Finel disaase or condition resulting in death) WOUMO Due to (or es a consequence of): Examiner physician and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that indiffered events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy performed? 2 NO 1 Nes 2□ No certificate 25. Wes case referred to medicel axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No Medical Certification: To 1 Inpatient 2X ER/Outpatient 3 DOA 28b. Time of tnjury 28d. Describe how injury occurred 27. Menner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the pompletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? After 1 Natural 5 Pending SUBSECT WAS SHOT BY POLICE 1 Yes 2 No 14 99 19001 Investigetion 2 Accident 6 Could not be determined 3 Duicide 28f. Location (Street and Number or Rural Route Number City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Homicide 12300 BLK GEORGIA BUT WHOTON HD 211190 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and litle of certifin O.C.M.E. April 15, 1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) MARYARITA D. KOREU W. 111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Ray 6/95

State Registrar

31. Date filed (Month, Dey, Year)

APR 3 0 1999

ORIGINAL

Sports

32. Registrer's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 22, 1999 6:45 PM MARILYN ELIZABETH RAGOO April 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 132 Old Enterprise Road Upper Marlboro Prince George's If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours Min. 1□ M 25 F Yrs. December 19,1941 Newport, RI 038-26-6054 Usuat Rasidanca of Decadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Yas 2 No Laurel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 U.S.A. 6953 Scotch Drive 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, Whita, atc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowad 4 € Divorced **Black** 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Coilega (1-4or 5+) Elementery/Secondery (0-12) Registered Nurse/Clinical Psychologist Health Care 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Beatrice Harris Louis Suggs 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2980D Mourning Dove Place, Waldorf, MD 20603 Lewis Powell/Son 20b. Piaca of Disposition (Nama of cametary, cramatory or other placa) 20c. Location - City or Town, Stata Date 20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donetion 5 Other (Specify) 04/29/99 Suitland, Maryland Cedar Hill Cemetery 22. Nama and Addrass of Facility
Cedar Hill Funeral Home, Inc. Sanatura of Funaral Sarvice Lige ellack 4111 Pennsylvania Avenue, Suitland, MD 20746 in dations that caused the death. Do not antar the mode of dyling, such as cardiac or respiratory errest, one cause on each line. shock, or haar try ure. List only o Approximete Intarval Batween Onsat and Daath Immediata Causa (Final disaasa or condition rasulting In daath) Brinss monst Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting in death) Lest Due to (or as a consequanca of): Dua to (or as a consequance of): 23b. Did tobacco use contributa to the ceuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to 24a. Was an autopsy complation of causa of deeth? 1 Yas 2 No 1 TYas 2 No 26. Placa of Daath (Check only ona) daughter's Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

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Physician/Medical Examiner þ Completed Be 0 Certification:

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760 88 signed by the a Division of Vital Records, should I certificate has b lirector, page 2 s Physician: director, this funeral After or Attending r death. d in by the f after Hospital 24 hours

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State Registrar

25. Was case raferred to medical axaminar? 1 ☐ Yas 3 € No residence 28d. Dascribe how injury occurrad 27. Menner of Death 28e. Date of tnjury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 T Homicida 29e. Certifian Certifying Physician: To the best of my knowledga, death occurred at tha time, date end place, and dua to tha ceuse(s) and menner es stated. (Check only one)

2 Medical Examinar: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, deta and place, and due to the cause(s) and manner stated.) 29c. Licensa number 29d. Data signed (Month, Day, Year)

29b. Signatura and titla of corty

30. Nema and addrass of person who complated causa of death (Item 23e) (Type, Print)

B. Redjace, M.D. 4 31. Data filed (Month, Day, Year) 4467 Old Branch Avenue #201, Temple Hills, MD 20748

32. Ragistrar's Signatura APR 2 8 1999

Sparke

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State of Maryland / Department of Health and Mental Hygiene 00

Physician · /Medical Examiner	1 II -	Decedent's Name (First, Middle, VINELLA M. RI		-	-17		100			2. Date of Dea			3. Time of Death
· /Medical	1 -	VINELLA M. RI	ZTD.									Year	
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	r li	e Facility Name (If not institution,	give street ar	nd number)				4t	. City, Town, or L	ocation of Death	4c. Cour	ty of Death	
		MARINER HEALTH	OF CI	RCLE 1	MANOR			K	ENSINGTO	ON	MONT	GOMERY	COUNTY
Funeral Director		. Social Security Number 219-94-3662	5. Sex 1 □ M 20		90 (In yrs. I	last birthday) Yrs.	If Under 1 Months [Yeer Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day NOV • 24		9. Birthp Coun JAM	lace (State or Foreign try) AICA
pu .	-	Jsual Residence of Decedent 0a. Stete 10b. County			10c City	. Town or Lo	cation					11	0d. Inside City Limits
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natural, adical Exp		15, Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most						on		16b. Kind of Business/Industry		lustry	
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d within plene. rr than rr than	se Completed	12	Oolie	AG (1-40)		HOME	EMAKER				OWNED		
単工長 5 4		7. Father's Name (First, Middle, La	est)						18. Mother's Nam	e (First, Middle,	Maiden Suma	ime)	
		SOLOMON REID							ADELLA S	SHARP			
PEE	_ -	19a. Informant's Name/Relationshi	p (Type, Prin	1)		19b. Meille	ng Address (S	Street a	nd Number or Ru		er, City or Tow	n, State, Zip	Code)
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permit. F Departme Importan any Injur		× . 4	4 0	1 .					N FUNERA	AL HOME			
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/Medical Examiner		Immediate Ceuse (Final disease or condition resulting In death)	е	erel	as a consec	quence of):	4	kude	M				
be axecuted sician end buriel-transit	Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.		Due to (or	ras a consec	luence of):						
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aw required is been so 2 should										24a. Was perfo	an autopsy omed?	ava	ere eutopsy findings ailable prior to mpletion ot cause deeth?
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(3)	3	0. Name and address of person w	no completed	cause of	death (Item	23e) (Type,	Print)	C11	- Also	VIIIC	WITT	W M	() 20 ×91
3		10. Name and address of person w	ASH E	R M	leath (Item	3720	ARRA	GU	TAVE	KENS	SINGTO	W, M	020893

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person training the plant

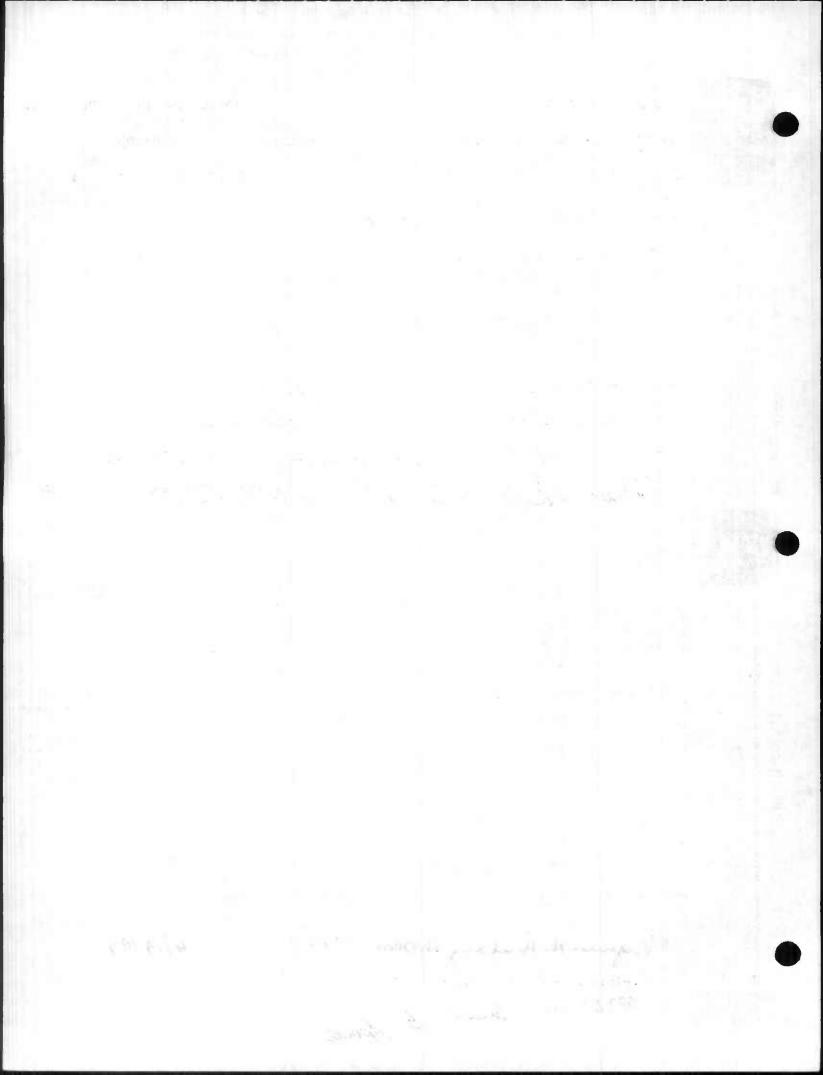
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3 Tima of Death **Physician** CHARLES APRIL 18^y RYALL 1999 9:40 a.m. /Medical 4a. Facility Neme (If not institution, giva straat and number) 4b. City, Town, or Location of Daeth 4c. County of Deeth Examiner DEER'S HEAD HOSPITAL CENTER SALISBURY WICOMICO 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foraign Country) **Funeral** Months Deys Hours 15M 20 F Director 220-03-4139 84 July 21,1914 Maryland Usuel Residence of Deceden with the Marylend 10b. County 10c. City, Town or Location ir than "natural", or items 23s or 28s-f show the Medical Exemples must be notified at 10d. Inside City Limits Director Maryland Wicomico 1 ☐ Yes 2 ☐ No Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 351 Deers Head Hospital Rd. 21802 USA Funeral 12. Was Decedent Ever in U.S. Armad Forcas? Was Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 11. Maritel Status Bleck, White, etc. filed within 72 hours efter Hygiene. 1 Nevar Merriad 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No Specify: Specify: White py 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Maintenance Engineer Campbell Soup Co. s 1 and 2 should be filed w Health and Mental Hygier tem 27 is merked other th 17. Fether's Name (First, Middla, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Robert Burlie Ryall Ora Lillian Taylor 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2:: Department of Health et important: if Item 27 is any Injury or other trau Betty Jean Webster/Friend 412H Woodview Square, Salisbury, MD 21804 20b. Placa of Disposition (Name of cematery, cremetory or other placa) 20a, Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stete 4/22/99 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) Wicomico Memorial Park 21. Signeture of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23e Print. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one ceuse on each the Approximeta Interval Between Onsat and Death Physician /Medical Immediata Ceuse (Finel disease or condition resulting in deeth) CONGESTIVE HEART FAILURE 3 WEEKS Examiner Due to (or es a consequence of) Physician/Medical Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS The law requires that the death cartificate be executed physician end s the buriel-trensit Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) P.O. Box 68760. Due to (or es a consequenca of): attending p signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR INSUFFICIENCY WITH ULCERATION, Records, þ Completed LEFT HEEL 24a. Was an eutopsy performed? 24b. Were eutopsy findings availabla prior to completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital I or Attending Physician: ofter death.

Director: After this certifications Be 25. Wes casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To 1 Yes 2 W No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA funerei 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours within 24 hour To the Funer completely file Medical 29a. Certifier 1ECertifying Physician: To the best of my knowledge, deeth occurred at tha time, date end piece, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D33905 MDOWD 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Virginia A. Dulany, M.D., CMD 31. Date filed 2.2 1999 32. Registrar's Signeture State Registrar & sparks



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Month Dev **Physician** 1999 4:30 pm Harry Edward Scarborough, Sr. May /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perry Point V.A. Maryland Health Care System Ceci1 Birthplece (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11,1921 If Undar 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) **Funeral** Deys Months 12 M 2 F Hours Pennsylvania 160-16-1127 78 Director Usuel Residence of Decedent 10d. Inside City Limits 10a Stete 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f ehow adical Examiner must be notified at 11 Yes 2 No Maryland Cecil Perryville Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21903 Concord Apts., Apt. 403, P.O. Box 280 U.S.A. Funeral 14. Reca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 Yes 2 No
If Yes, Give
Yaar or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 1944 the Medical Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) JFK Highway Administration Elemantary/Secondery (0-12) Eight Years College (1-4or 5+) Perryville, Maryland Maintenance 7 is marked other traumatic event, i 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If New 27 is marked other any lightry or other traumatic event DIDE. Be Herman E. Scarborough Mary L. Strimmel 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Concord Apts., Apt. 403, P.O. Box 280, Perryville, MD 21903 Florence A. Scarborough (wife) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5/3/99 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture Funerel Servica Lice 22 Name and Address of Fecility Lee A. Patterson & Son Funeral Home 23e. Part1. Entar tha disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medicai Immediate Cause (Final Esophageal Carcinoma 1 Month disaasa or condition Examiner Dua to (or as e consequance of): Examiner physician end the buriel-transit Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disease or Injury that initieted avents resulting in death) Last Dua to (or as e consaguança of): Physician/Medical Dua to (or es a consequença of) attending p 80 signed by the a 23b. Did tobacco use contributa to the causa of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probabty 4₺ Unknown þ 24b. Wara autopsy findings evalleble prior to completion of cause of daath? been si 24a. Wes en autopsy parformed? Completed s certificate has b 1 Tyes 2 No 1 ☐ Yes 2 ☐ No director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2⊠ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Tima of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 Yas 2 No after death Director: A 3 in by the f 2 Accident 6 Could not be determined 3 Suicide 28a. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dil completely filled in to certifying Physician: To the best of my knowledge, deeth occurred at the time, data and pleca, end due to the causa(s) and mennar as stated.

2 Medical Examinar: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at the time, data and placa, and due to the cause(s) 29e. Certifier Medical (Check only one) end menner steted. 29d. Date signed (Month, Dev. Year) 29b. Signature and so of certifier 29c. Licansa number D32395 May 1, 1999 30. Name end address of person who complated cause of daath (Itam 23a) (Type, Print) Thomas Finucan, M.D., V.A. Maryland Health Care System, Perry Point, Maryland 21902 31. Deta filad (Month, Dey, Yeer) 32. Ragistrer's Signeture

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Registrar

MAY 03 1999

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filed within 72 hours efter death with the Meryland Hyglene.

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

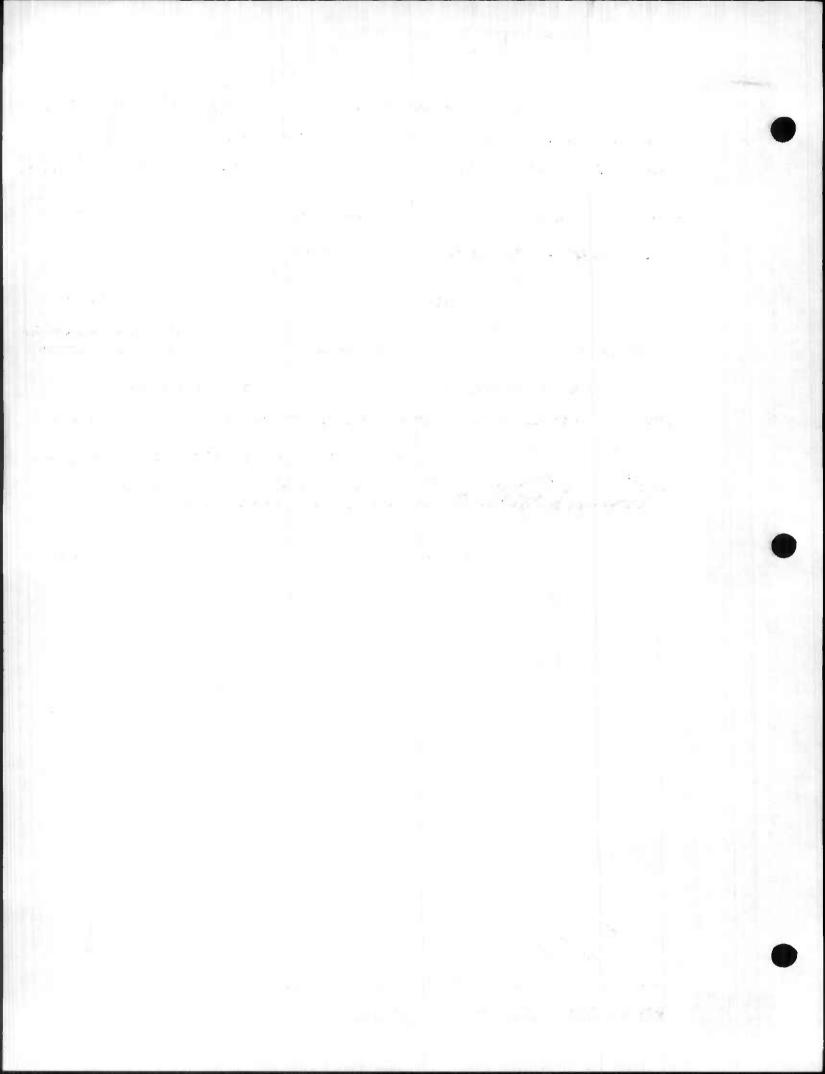
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Division of Vital Records, P.O. Box 68760,

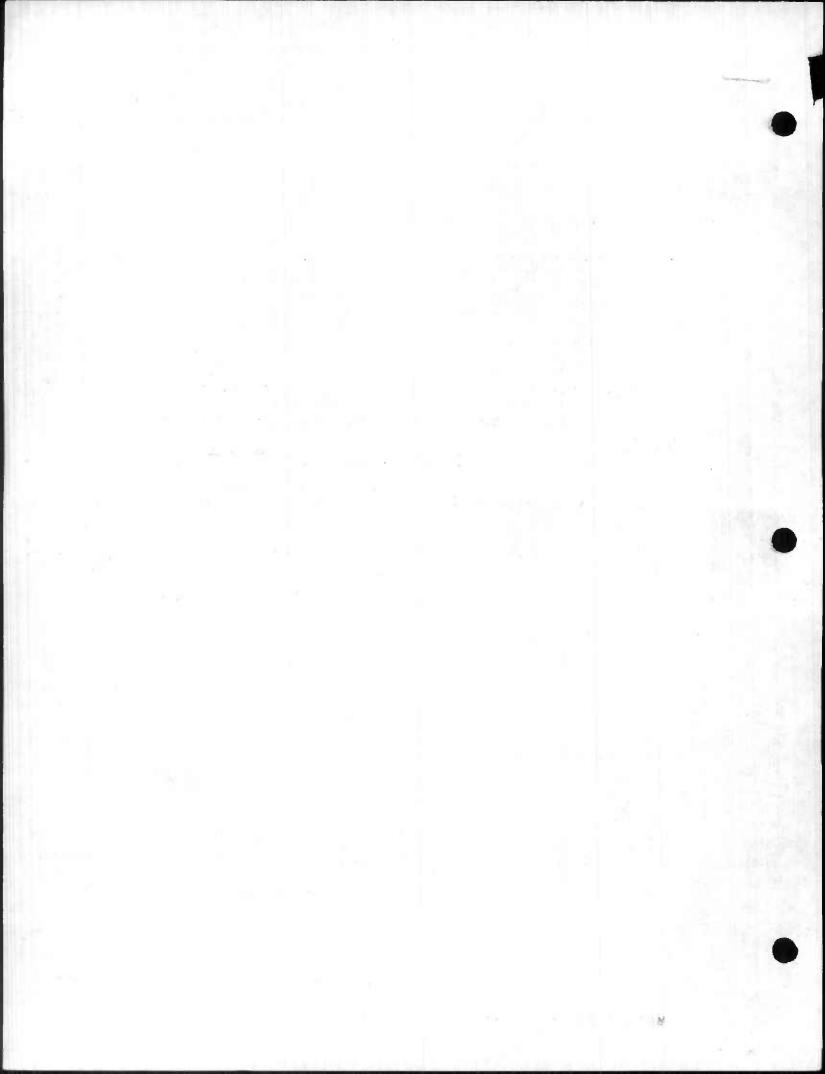


State of Maryland / Department of Health and Mental Hygiene Amended Items 20a, b, c 5/3/99 Certificate of Death Reg. No. T. Decedent's Neme (First, Middle, Last) 2. Dete of Death APRIL **Physician** EL12ABETH SHERLOCK 30, 1999 16:54 PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (Stefe or Foreign Country) **Funeral** Months Days 1 M 2 KF Hours 48 213-46-3133 May 19, 1950 Delaware Director Usual Residence of Decedent the Meryland 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland n/a Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 hema 23a United States Funeral 402 South Regester Street 21231 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours after a Department of Health and Mental Hygiens. Introcrant: If Item 27 is merked other than "natural", or her any Injury or other traumetic avenue. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 White 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) 12 Office Manager Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth M. deHan Michael J. Sherlock 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Kyle Sherlock/ Sister 30 Crescent Lane, Elkton, Maryland 21921 20b. Piece of Disposition (Name of R. A. Dete cemetery, crematory or other place)

Intimaculate Ferris & Co. 5/4/00 20a. Mathod of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from Stete West Chester, PA. 4 ☐ Donation 5 ☐ Other (Specify) 5/1/99 Cherry Hill, Maryland Cemetery-Conception 21. Signeture of Funerel Sarvice Licensee 22. Name end Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921 2/10 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each lina. Approximeta Intervel Between Onset and Death **Physician** Immediete Cause (Finel disease or condition rasulting in daath) ADENOCARCINOMA /Medical DISSEMINATED UNKNOWN Examiner Due to (or as e consequence of) Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequenca of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings svailable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Mannar of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred After 1 Natural
2 Accident 5 Pending n 24 hours after death.

Ne Funeral Director: Alpletely filled in by the fu death. 1 TYes 2 No investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ŏ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the tima, date and place, and due to the cause(s) end menner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and # 29c. License number MEDICAL RESIDENT ADRIL 30, 1999 30. Neme and auditions of person who completed cause of deeth (Item 23a) (Type, Print) 8 MBONU, 600 N. WOLFE ST. BALTIMORE, MD 21287 CHARLES C. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar MAY 03 1999 books



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þ	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:			Vas Decadent of Yes, specify C ☐ Yes XX			cify Yes or No Rican, etc.)		ce - Americ ck, White, y: B1 a	
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To Be Comp	2	Jim McKnight					E1	la D	obbins	5		
		19a. Informant's Name/Relationship (T)	/pe, Print)							ear, City or Town,		
		Winnie Clark,	Sister				cth P	1.,		Hill, N		20745
	-	20a. Method of Disposition N Burial 2 □ Cremation 3 □ F	Removal from State	cem	etery, crem	sition (Neme of setory or other p	elece)		Date	20c. Location	-	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Dev APRIL 22,1999 12:57 am CELIA S. SULLIVAN 4b, City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES 8. Date of Birth (Month, Day, Year)
JUNE 8, 1922 5. Social Security Number if Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthday) Deys 1 M 2 NE Months Hours Min SOUTH CAROLINA 76 Yrs. 578-46-3559 Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1▼ Yes 2 No CAPITOL HEIGHTS PRINCE GEORGES 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 748 SUFFOLK AVE 20743 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Bleck, White, etc 1 Never Married XX Merried 1 Yes 2XXVo Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) PRIVATE PAYROLL TECHNICIAN 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) WALTER GRADEN LULEE BEEKS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) CELIA SULLIVAN / DAUGHTER 748 SUFFOLK AVE, CAPITOL HEIGHTS, MD 20743 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from Stete 4-27-99 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND NATIONAL CEM LAUREL, MD 22. Name end Address of Fecility 21. Signeture of Funerel Service Licensee

ALEXANDER S. POPE FUNERAL

5538 MARLBORO PIKE, FORESTVILLE, MD 20747

I is marked other than "naturel", or items 23s or treumstic event, he wed as Examiner must be a permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiana. Important: if item 27 is marked other than "natural", or item any injury or other treumstic event, its Medical Examples. Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

10e State

Director

Funeral

by

Completed

Funeral

Director

288-1 the

with

death

10 1/9

Physiclan /Medical Examiner

physician end s the burial-trans Physician/Medical 80 ed by the deteched signed by t à Completed peed has e 2 page certificate director, Be To this Certification: After

The law requires that the death certificate be executed

or Attending Physician:

death.

within 2.
To the F

Director: A in 24 hours the Funeral Director of the Funeral Direct

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Finel Examiner

disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest

23a. Pert1. Enter the discrete, or complications that caused the deeth shock, or heart feilure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory errest,

Due to (or es e consequence of)

Due to (or es a consequence of)

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24e. Wes en eutopsy

1 Yee

24b. Were eutopsy findings aveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes

3 Probably 4 Unknown

23b. Did tobacco use contribute to the cause of death?

2 No

Approximete Intervel Between Onset end Deeth

25. Wes cese referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth 1 Statural 2 Accident

5 Pending investigetion 6 Could not be determined

28a. Dete of injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpetient 28b. Time of

28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)

3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Sulcide

4 Homloide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29c. License number 29d. Dete signed (Month, Dey, Year)

29b. Signeture end title of certifier

30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)

3001 HOSPTIAL DRIVE, CHEVERLY, MD MEERA KANHOUOA, MD 31. Dete filed (Month, Dey, Yeer) APR 2 8 1999

State Registrar

Medical





Land Call Triving State

State of Maryland / Department of Health and Mental Hygien 9 | 5563

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Examin		4a. Fecility Neme (If not Institution, g		m <i>ber</i>)				4b. City, Town, o	or Location of Dee		ity of Deeth	2.20 11
		Magnolia Gardens	Nursin	g Home				Lanham			ce Geor	rge's
Funeral			Sex	7. Age (In yrs.	lest birthdey)	If Under 1	Yeer	If Under 24 H	rs. 8. Dete of B in. (Month, D			
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netural', or items 23a or 28a-f show dical Examiner must be nutified at		10e. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d	d. Inside City Llmi
25	to	MARYLAND PRINCE	GEORGE !	S GI	REENBEI	T						1 ☐ Yes 2/☐ N
natural', or items 23a or 28a-f show diest Examiner mant be notified at	Director	10e. Street end Number	-2001102			10f. Zip Co	ode			10g. Citizen o	Whet Country	17
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or the		1 Never Married 2 Married	2 🗌 No		1 Tes, specify			erto Hican, etc.)		eck, White, etc	3.	
	by	3 ☐ Widowed 4 ☐ Divorced	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Detes: WW					Specify:		Spec	"y: WHIT	E
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	10	JAMES A. SORRELL						MARY V	. ALLEN			
traumatic		19e. Informent's Neme/Reletionship	(Type, Print)		19b. Maill	ng Address (S	treet		Rural Route Num	ber, City or Tow	n, Stete, Zip C	ode)
4 5		MARGARET SORRELL	WIFE		7718	HANOVE	R	PARKWAY	, APT. #	303. GR	EENBELT	MD 20
other	Ì	20e. Method of Disposition	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20b. F	Plece of Dispo	sition (Neme	of		Dete		- City or Town	
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any Injury or ance.		21. Signature Funeral Service Lice		FU	-	ICOLN C 2. Name end A			4/26/99	BRENTW	00D, M	ARYLAND
any	- 1	10.0	n						RAL HOME			
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deteched for	000	Pert II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying caus	e div	ren in Pert I	23h. Dio	I tobacco use c	ontribute to th	he cause of death
tech	Physician						o gii			Yes 2 No		bly 4 ☐ Unkno
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yd n		4 ☐ Homicide determined	286. Piece	of Injury - At ho ng, etc. (Specify	ome, ferm, str v)	eet, fectory, of	fice		28f. Location City or To	(Street and Num wn, Stete)	ber or Rural R	ioute Number,
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11		30. Neme end address of person who	completed cause	a of deeth (Item	23e) (Type	Print)				- (
6		Neelam Ashai, M.						#220 P	owie Ma	rv1and	20716	
State	3	31. Date filed (Month, Dey, Year)		egistrer's Signe		TE VA.	,	"ZZU, DO	wre, ma	гутана	20/10	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item #6.Per Family PGC State of Maryland / Department of Health and Mental Hygiene O #7.Per FHPGC 4-28-99 cr Certificate of Death Amend item 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** 4b. City, Town, or Location of Death 16, 1999 arrie >1mms /Medical 4a. Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. Md 5. Social Security Number 6. Sex Southern linton Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign Country)
9. Knoxville, Tenn **Funeral** Months Days Hours 578-38-8118 69 Director November 26 1929 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show show Director DC N/A Washington, D.C. Yes 2 No 10e. Street and Number 10f. Zlp Code 10g Citizen of What Country? flams 23a 1379 Savannah Place, S.E. 20032 Funeral United States America 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or itam solical Examiner filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 **Black** 1 ☐ Yes 2 No Specify. by Specify 3 ☐ Widowed 4 ☐ Divorced Completed Pages 1 and 2 should be filed within 72 ho nant of Health end Mental Hygiena. sat: If Item 27 Is marked other than "natur ury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Self Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Dean Sweetie Bell Griffin 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Simms - Husband 1200 Delware Avenue, S.W. #710; WDC 20024 20a. Method of Disposition

1 Burial 2 □ Cremation 3 □ Removal from State 200 Place of Disposition (Neme of semetery, cremetory or other place) 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or Glenwood Cemetery 4/24/99 4 ☐ Donation △5 ☐ Other (Specify) Washington, DC 22. Name and Address of Fedility Robert O. Freeman Funeral Svcs, INC emierr 1353 H Street, N.E.; Washington, DC 20002 23a. Pert1. Enter the disease, or complication—that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a donsequence of) Box 68760. Physician/Medicai the to (or as a consequence of) Jan P.O. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? peen 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Death 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affar Division Attending 5 Pending Investigation 1 Netural deeth. 1 Yes 2 No 2 Accident after deeth Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide I in by t 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) DE25640 April 16, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Buite 202; lubshington Southern 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State APR 2 8 1999 Registrar

The state of the section of

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death April Day 1999 6.45AM 27 HATTIE VICTORIA 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Manor Care Health Services Prince George's Largo If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) Deys 1 □ M 2 🗓 F 93 Yrs. November 7, 1905 Alabama Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince George's Largo 10f. Zip Code 10g. Citizen of Whet Country? 20774 600 Largo Road U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14, Raca - American Indian, Bleck, White, etc. 1 Yes 2 X No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married specify: Black 1 Tyes 2 No Specify: 3 K Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Domestic Worker Private 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Jannie Frazier Henry Lewis 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 604 Juneberry Court, Bowie, Maryland 20721 Janice Motley/Niece 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 05/02 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 1999 4 ☐ Donetion 5 ☐ Other (Specify) Walter Jones Cemetery Autaugville, Alabama J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 Vercen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-fatilitie. List only one cause on each line. Approximete Interval Between Onset end Death Failure to thero sclero si Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 □ Yes 2 □ No investigation 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be axecuted attending phyor Attending Physician: r death. a Funeral Director: A Setely filled in by the f Hospital

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be not filed at once.

Physician /Medical

Examiner

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signed by the a

certificate has b lirector, paga 2 s

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After

Physician/Medical Examiner

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Completed

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To

Certification:

Medical

5. Sociel Security Number

419-64-7147

10e. Street and Number

12th

20a. Method of Disposition

Nance

Immediate Ceuse (Final disease or condition resulting In death)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury

thet initiated events resulting in deeth) Last

1 Yes 2√ No

27. Manner of Deeth

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

11. Marital Status

To the Hosp within 24 hor To the Fune completely fi 4

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of cartifier

APR 2 8 1999

32 Registrer's Signature

anong MD

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
RAKESH A RORA, MD, 14300 GALLANT FOX LN, BOWIE MD20715

29c. License number

20108

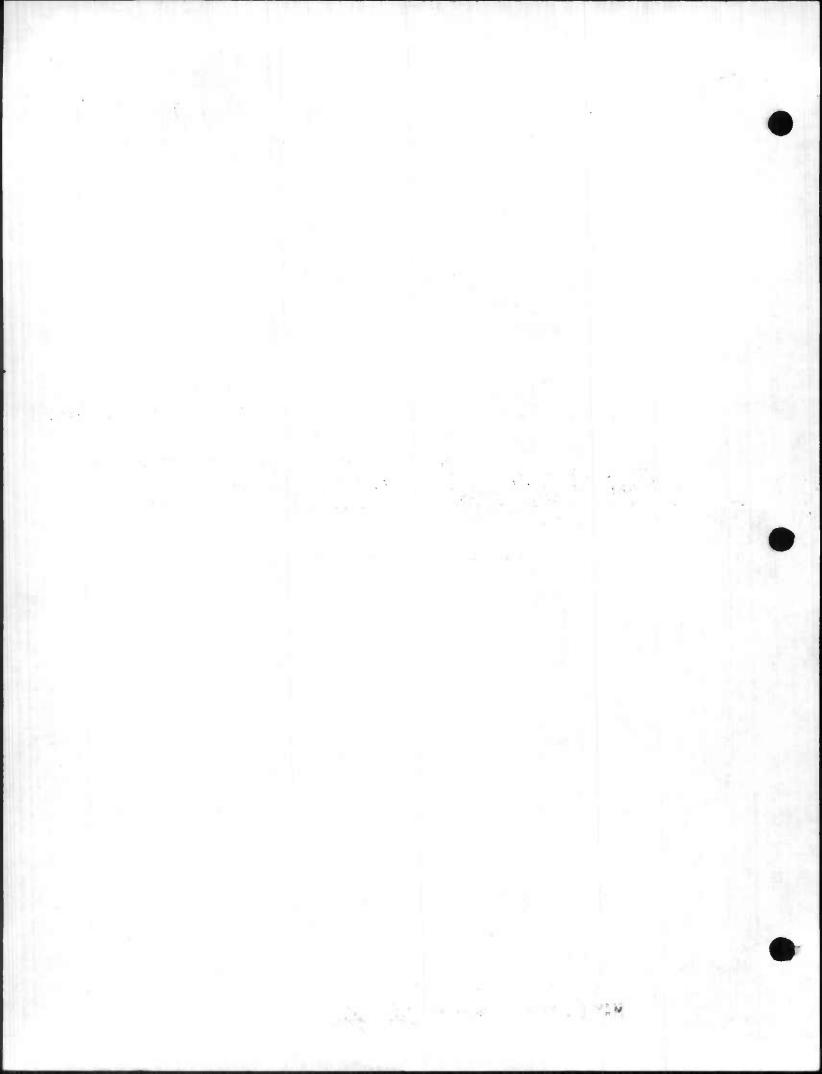
29d. Dete signed (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	Harold	2	praque	<u> </u>	Tay 1	1999 Z:10 A			
Examiner	4a Facility Name (If not institution, give s			4b. City, Town, or Location	on of Death 4c. County	of Death			
	2450 Shawnee Lan		Milledge d Vers	Waldorf	Char				
Funeral Director	402-30-2341	M 2□ F 7. Age (In yrs. last bit	rthday) If Under 1 Year Months Days	Hours Min. (Date of Birth Month, Dey, Year) Oril 13,1937	Birthplace (Steta or Foreign Country) Texas			
P 8-	Usual Residence of Decedeni 10a. State 10b. County	10c. City, Tow	m or Location			10d. Inside City Limits			
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with the Marylar as or 28s-f show 1.be notified at 1. Director	10e. Street and Number 2450 Shawnee Lan	e	10f. Zip Code 20	0601		10g. Citizen of What Country?			
fler death w r ltems 23s siner must.	11, Marilal Status	2. Was Decedent Ever In U.S.	13. Was Decedent of I	Hispanic Origin? (Specify san, Mexican, Puerto Rica	Yes or No- 14. Race	- American Indian,			
	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Ayes 2 No 1 Yas, Give Year or Dates: 1964	II Yes, specify Cub		n, etc.) Black Specify:	k, white, atc. White			
22 should be filed within 72 hours at an and Merial Hygional Hygional Francisco of its interestic event, the Medical Exam. To Be Completed by 8	15. Decedent's Educ		. Decedent's Usual Occup	pation	16b, Kind of Bus	siness/Industry			
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Month Month									
C II M P	19a. Informant's Name/Relationship (Typ. Crystal L. Miller/D	aughter 29	9860 Claire	Circle, Mec	hanicsville,	Md. 20659			
samit. Pages 1 a Separtment of Hea mportant: If Item iny Injury or othe RIGS.	20a. Method of Disposition 1 ☐ Burial 2 🖟 Cremation 3 ☐ Re		ol Disposition (Name of any, cremetory or other ple	Di Di	ate 20c. Location - 6	City or Town, State			
Pag ment ant: II ury o	4 □ Donation 5 □ Other (Specify)		Crematory	May 2	,1999 Waldo	rf, Maryland			
with the state of	21. Signature of Funeral Service Life)sa	· 0	22. Name and Addre	ess of Facility					
mew	MARK G. BROHA	WN M00053	P O Box	t Funeral Ho	of Manyland	20604			
	MARK G. BROHA 23a. Part1. Enter the disease, or compile shock, or heart failure. List only on	ations that caused the death. Do e cause on each line.	not enter the mode of dyi	ng, such as cardiac or res	piratory arrast,	Approximate Interval Between			
Physician						Onset and Death			
/Medical Examiner	Immediate Causa (Final disease or condition	COLON	CANO	LER					
	rasulting In death)		consequanca oi):						
executed in and initiansit	b.								
and and i-tran	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequenca ol):						
death certificate be executed e attending physician and nd for use as the burist-transit	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury c.								
ficate be e physician as the buria	that initiated events resulting in death) Last	Due to (or as a	consequenca of):						
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The lew requirements that has been so page 2 should Completed					1□ Yes 2 No	1 Yes 2 No			
certificate rector, pag	25. Was case raferred to medical			26. Place of Death (Cl	-	10169 20160			
	examiner?	ospital:	utpatient 3 DOA Ot	her:	5 Residence 6 □Othe	or (Specify)			
Physical distriction of the Transfer of the Tr	27. Marrier of Death		Time of 28c. tnju		Dascribe how Injury occurre				
ding Phy th. After thi funeral	Natural 5 Pending invastigation	(Month, Day Year)		ork?]Yes 2□No					
Attending or deeth. ector: After by the fune	3 ☐ Suicide 6 ☐ Could not be	28e. Placa of Injury - At home, fa	arm, street, factory, office		Location (Street and Number	er or Rural Route Number,			
tal or Attending P rs after deeth. al Director: After t led in by the funer: Certification:	4 Homicide	building, etc. (Specify)			City or Town, State)				
	29a. Certifiar 42 Certifying Physi	clan: To the best of my knowledge	a, death occurred at the ti	me, date and place, and o	due to the cause(s) and me	nner as stated.			
ne Hospi no 24 hou ne Funer pletely fill edical	(Check only 2 Nedical Examinations)	er: On the basis of axamination an and manner stated.	nd/or investigation, in my	opinion, death occurred a	tha tima, data and place, a	nd due to the cause(s)			
Withir To the	29b. Signature and title of certifiar		29c. Licen	se number	29d. Date signed	(Month, Day, Year)			
	1 south	M Hoth	~ n	(75g)	511	99			
	30. Name and address of person who con	npleted cause of death (Item 23a)	(Type, Print) A			1			
	PO ROX	2750	1 alle	ta mod	2064	5			
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signature							
Registrar	MAY 0 4 199	19 Deneva	B. Som	41					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Amended # 18, P.G. G.C. 5/3/99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, 1999 Charles Sibert, SR. April 4:40PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner University of Maryland Medical System Baltimore, MD Baltimore city If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 18 M 20 F 577-56-4954 Director 56 McCormick, SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Heelth end Mentel Hygiene. Introportant: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, or a Medical Examiner must be notified anong. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 Falcon Drive 20772 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 1 1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 € Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Afro-American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th 3 yrs. Metro (Transit) Transportation 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Celia Mae Mackie Sibert Dennis Sibert, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lydia J. Sibert (Daughter) 1803 Tulip Ave., Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation S ☐ Other (Specify) Riverdale Park Crematory | 4/30/99 Riverdale, MD 22. Name and Address of Fecility 21. Signature of Juneral Service License Dudley Funeral Home mund Edward M. Dudley | 3200 Rhode Island Ave., Mt. I Pager Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one ceuse on each line. 3200 Rhode Island Ave., Mt. Rainier, MD 20712 Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical . Sepsis Examiner Due to (or as a consequence of): Examiner pneumonia physician and s the burial-trensit The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) ettending pl Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown multiple myeloma 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? Aftar this certificeta has funeral director, page 2 SELNO 1 ☐ Yes 2 No 1 Yes or Attending Physician; Be 25. Was cese referred to medicel exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how Injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No efter deet Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide n 24 hous. the Funeral Directified in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

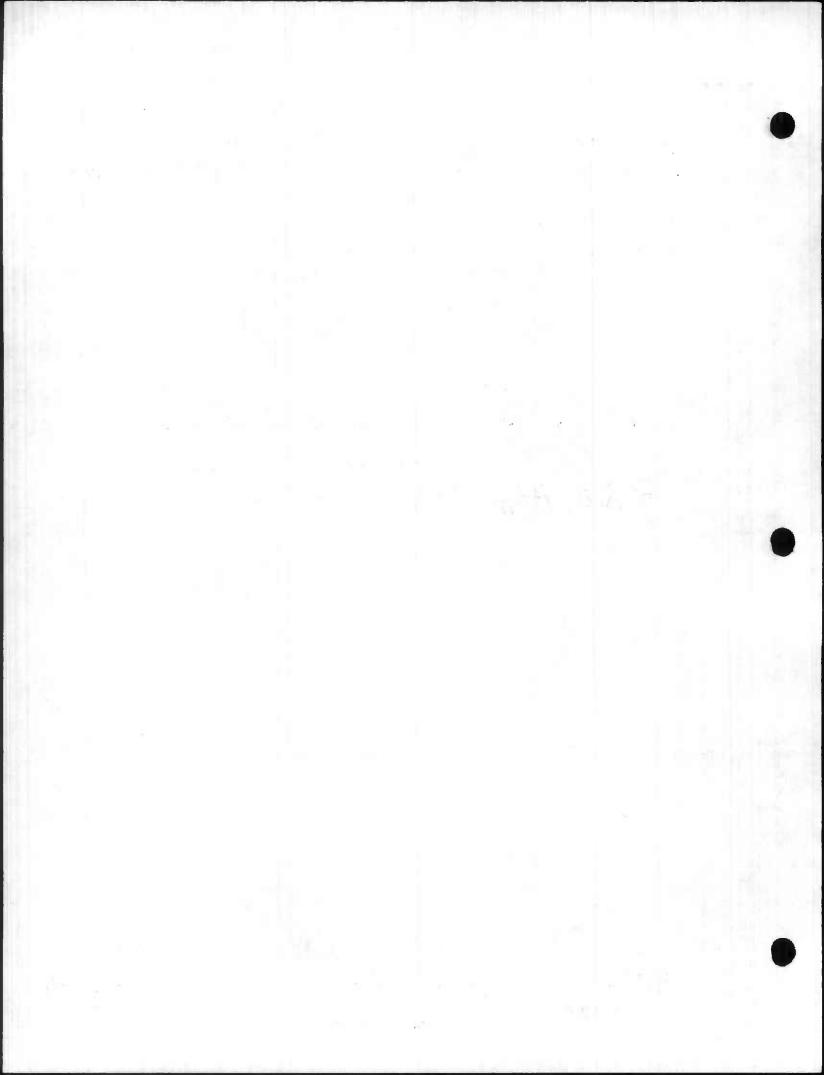
Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number ama Hude April 26, 1999 P9874 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 4611 Roland Avenue Apartment #3 Battimore MDZ1210 Tania Hudson

32. Fegistrar's Signeture

Registrar

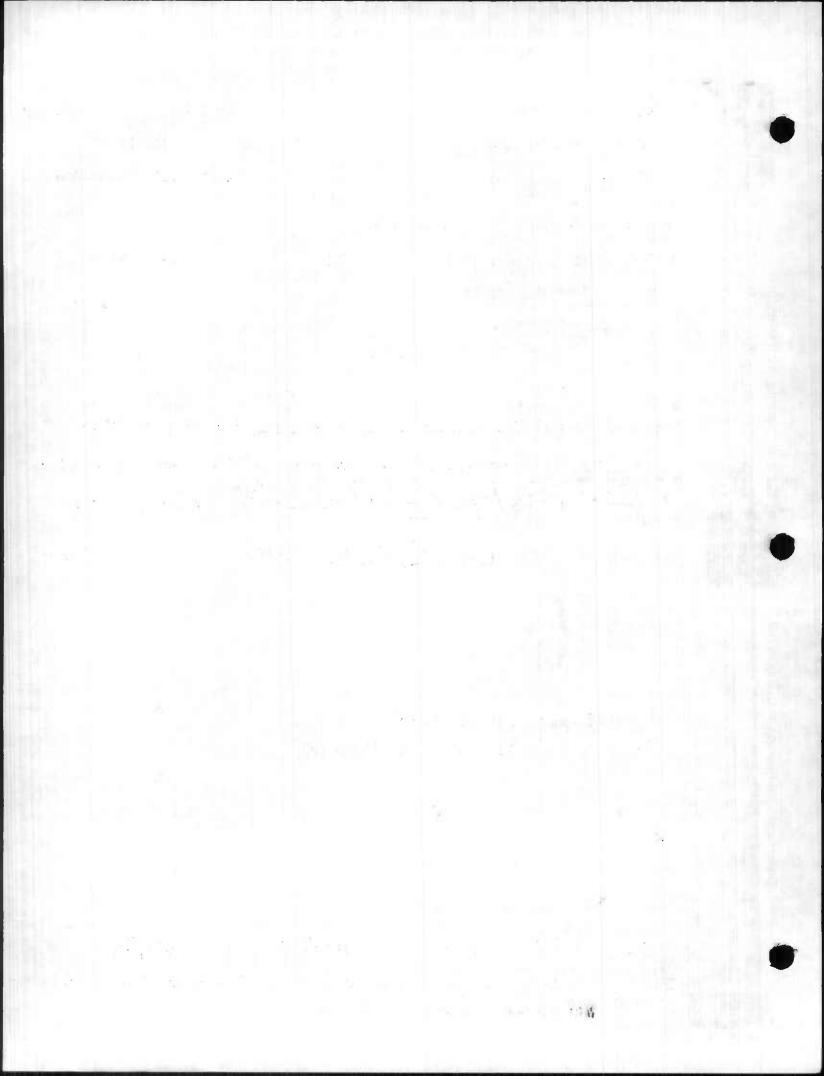
OF WORK

	State of Maryland / Department of Health Certificate of Death	Reg. No. 9	9 15568
Physician /Medical	1. Decedent's Name (First, Middle, Last) Harlan JEFFERSON Sherid	an April 27, 199	9 3. Time of Death 2:40 PM
Examiner Funeral Director	, , , , , , , , , , , , , , , , , , , ,	bury, MD Wicom	ny of Death LICO 9. Birthplace (State or Foreign Country) DELAWARE
De Bu	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Maryla e-f sho illed at	MARYLAND WICOMICO SALISBURY		1 ☐ Yes 20 No
or 28s-f a be notified Directo	10e. Street and Number 10f. Zip Code	10g. Citizen of	What Country?
			S.A.
natural", or hems 23. Scal Examiner must	3 ☐ Widowed 4 ☐ Divorced Specify Year or Dates: NAVY	n, Puerto Rican, etc.) Bla	ce - American Indian, ack, White, etc. fy: WHITE
ygiene werthan "natura k, the Medical J Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	st of working	Business/Industry
		USPO	OSTAL SERVICE
Mental H marked out matic ever	JOHN EDWARD SHERIDAN BE	ERTHA W. BAKER	
The man		per or Rural Route Number, City or Town	
opes 1 and t of Heat if Nem 2 or other	FRANCES SHERIDAN - WIFE 20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete 20c. Location	- City or Town, State
famon famon famt:	4 □ Donation 5 □ Other (Specify) SPRINGHILL MEMORY GAR		ON, MARYLAND
Department of the partment of	21. Signature of Funeral Service Licensee	705 E.	MAIN ST.
	BOUNDS FUNERA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as		BURY, MD 21804
Cate be executed physician and the burist-transit the burist-transit colors.	Immediate Cause (Final disease or condition resulting in death) a. Characteristic disease or condition pue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury cause) (Disease or Injury cause)	palmay	your,
E 04 2	resulting in death) Last Due to (or as a consequence of):		923.
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s been s 2 should pieted		24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
page page		1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No
is certificate director, pag	examiner? Hospital: Other:	e of Deeth (Check only one)	
si di di	27. Menner of Death 1 Inpatient 2 EN/Outpatient 3 DOA 4 N 27. Menner of Death 1 Netural 5 Pending (Month, Day Year) 1 North	ursing Home 5 Residence 6 Ott	
to the nospital of Attending Parith 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	2 Accident 3 Suicide 4 Homicide Accident 28f. Location (Street and Num City or Town, Stete)	nber or Rural Route Number,	
within 24 hours and the Funeral Completely filled	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete are considered in the constant of the c	nd plece, and due to the cause(s) end meth occurred at the time, date and plece	nenner es stated. , and due to the cause(s)
Withir Comp	29b. Signature and title of certifier 29c. License number	29d. Date sign	ed (Month, Day, Year)
AL.	0283	47 4/2	0/99
15x1V	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	way Dr. Sali	sbury MD
State Registrar	31. Date filed (Month, Day, Year) APR 2 9 1999 32. Registrar's Signature	J	

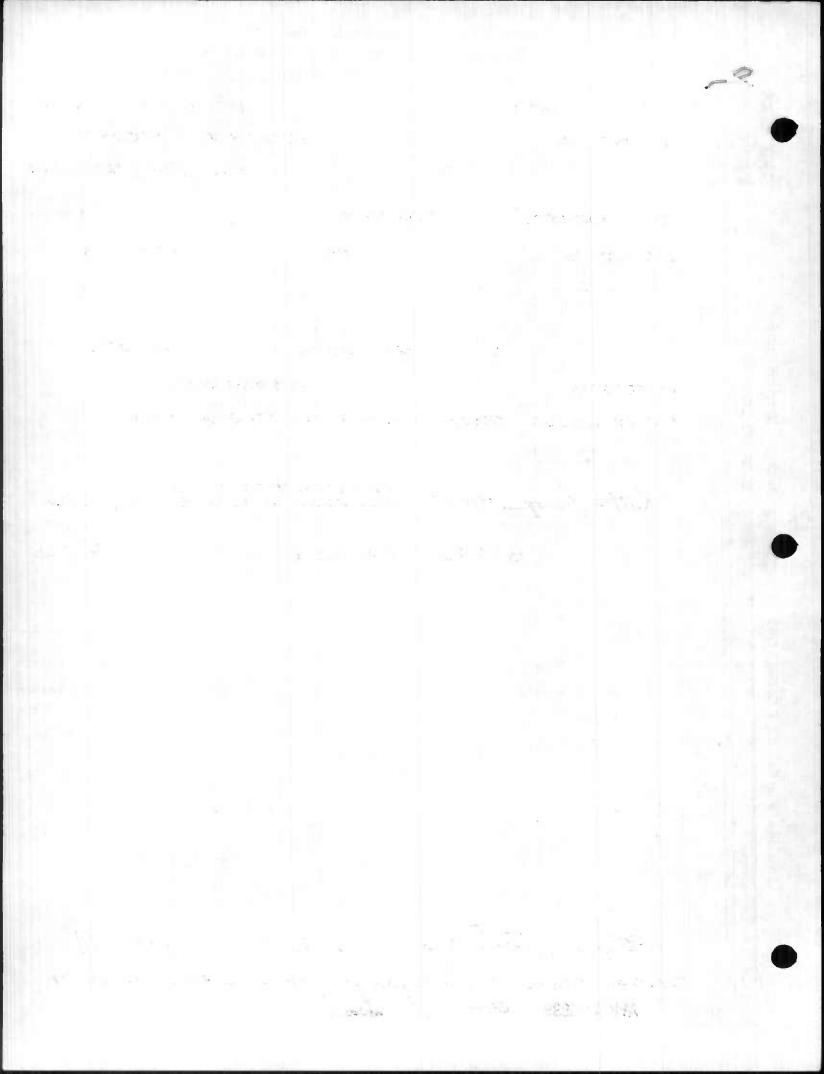


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	1.	Decedent's Name	e (First, Mide	dle, Last)					Death	2	. Date of De			3. Time of
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	_	Da. State	10b. Count	ty		10c. City	y, Town or Loc	ation	***********					10d. inside Cl
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	10	De. Street and Nur	mber					10f. Zip Code				10g. Citizen of	What Cou	ntry?
		2501 Coa	ch Hou	use w	ay Apt	. 1B		21702				United		
	11	Marital Status		ırrled	2. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	No No		/as Decedent of Yes, specify Cul		/ (Specruerto Ri	by Yes or No can, etc.)	Specil	ck, White,	can Indien, etc. hite
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niner	13000	(If not institution, give	street and num!	ber)						ocation of De SPRING		4c. County	of Desth	RY
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	1 X Burial	2 Cremation 3 II		tate	cemetery, cre	matory or o	thar ple		1	4-24-9		BRENTW		
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	tmmediate Cause disease or condit rasulting In daath	tion	BRI			Cou							-	Approximete Intervel Between Onset end Deeth
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Medical Certification: To Be Completed by Physician/Medical Examiner	disease or condit rasulting in death saulting in death saulting in death if sny, leading to cause. Enter in Cause (Disease that initiated ever resulting in death per li. Other eigr 1 Yes 2 27. Manner of De 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifiar (Check only	conditions, immediate derlying or injury hts i) Lest erred to medical hoo ath 5 Pending Investigation 6 Could not be determined 1 Certifying Phy 2 Medicat Exam	b	Due to (c Due to (c Due to (c Due to (c Ath but not res It injury Dey Year) of Injury - At h g, etc. (Speci	for as e consector es a consector es	equence of): quence of): quen	cause give 28c. Injur World 1	26. Place 26. Place 4 November 27 November	L. De of Dea	23b. Date of the Check on the C	Yes Yes Young Yes Young Yes Young Yes Young Yes Young Yes Young Yes	a 6 □Oth injury occurrence Numbersele)	24b. Way co of 1 (in the control of	onset end Deeth on the cause of death bebly 4 Unknown ara sutopsy findings aliable prior to empletion of cause deeth? Yes 2 No fy) al Route Number, stated. on the cause(s)



Amend item # 20b. & 20c. Per FH PGC 5-3-99 Cr Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 9:33 Pm Jeanne V. Thompson 1999 APR 23 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1□M 2⊠F Months 578-88-2611 60 Director 10/8/38 Wash., D.C. Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic svent, the Mexical Examinal must be notified at Md. 1X Yes 2 No Rockville Director Montgomery 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1301 Piccard Drive 20850 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detea: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or flen any injury or other traumatic avent. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 2 yrs. Elementery/Secondery (0-12) G.A.O. Typist U.S.Gov't. 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middle, Last) Clarence W. Turner Martha Slaughter 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19e. Informant's Name/Ralationship (Type, Print) Clarence W. Turner/Father 1032 49th St., N.E., Wash., D.C. 20019 20b. Place of Disposition (Name of cometary, cremetory or other place)

Glenwood Cem
Forest Hills Cemetery 5/1/99 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removel from Stete Clinton, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. Jany 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel diseese or condition rasulting in death) /Medical 1 HUR Examiner Dua to (or as a consequence ot): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Diseasa or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown agreatention Completed by 24b. Were autopsy tindings aveilabla prior to completion of cause of death? 24a. Wes en eutopsy performed? Schiro Affective DISORDER has 1) efression 20 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case raterred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this of funeral dir 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of tnjury 28d. Describe how injury occurred 28c. Injury et Work? To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Oirector: After ti completely filled in by the funera 5 Pending Invastigation 1 SNatural 1 Yes 2 No 2 Accident 8 Could not ba 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicida edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to tha cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbar 29d. Date signed (Month, Day, Year) 00053528 April 25, 1999 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shop Efield Rd. SilvER SPRING MD 2502 2309 MD DAPHNA HENKIN 31. Dete tiled (Month, Day, Year) 32t Registrar's Signature State APR 3 0 1999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 1224 TYLER RACHEL and 28 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | December 22, 1910 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1□M 22 F 214-34-5244 88 Yrs. Maryland Usuel Rasidance of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Somerset Rhodes Point 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 3293 Marsh Road 21824 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 MNo If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White 3℃ Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) Homemaker At Home 17. Fether's Neme (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Sumame) Benjamin Evans Effie Evans 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) T. Alan Tyler (Son) P. O. Box 41 - Rhodes Point, MD 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removel from State Calvary Church Cemetery 5/2/99 Rhodes Point, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature & Fuheral Service Licen 22. Name end Address of Fecility Bradshaw & Sons Funeral Home de Robert H. Bradshaw, Jr. 306 W. Main St. - Crisfield, MD 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiretory arrast, shock, or haart feilure. List only ona cause on each line. Approximeta Onsel end Deeth Immediate Ceuse (Finel diseese or condition resulting in daath) es e consequence ol): Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in daath) Lest Due to (or es e consequença ol) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Inknown 1 ☐ Yes 2 ☐ No 24b. Were sutopsy lindings eveileble prior to 24e. Wes an autopsy performed? completion of cause of death?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Modical Examinat must be notified at

death with the Maryland

filed within 72 hours after

1 and 2 should be Health end Mental

Pages nent of h

Baltimore.

nt of Health e If item 27 is or other tra

Department of Important: If any injury or otice.

Examiner the burial-transi Physician/Medicai signed by þ director, page 2 should be Completed certificate hes or Attending Physician: offer death.

Director: After this certifications Be 2 Certification:

of Vital Records, P.O. Box 68760

Right lower lobe prummer

1 ☐ Yas ANO

1 ☐ Yes 2 ☐ No

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

	exeminer?	-4	10	modical
27	Menner of	Deeth		

5 Pending investigetion

6 Could not be datarmined

28a. Date of Injury (Month, Dey Year)

Inpalient 2 ER/Outpetient 3 DOA 28b. Time of

28e. Pleca of Injury - At home, farm, street, lectory, offica building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yas 2 ☐ No

28d. Describe how Injury occurred

29a. Cartifian

Neturel 2 Accident

3 Sulcide

4 Homicida

Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stelled.

29b. Signeture end title of certilier

29c. License number

29d. Date signed (Month, Day, Year)

Sales bury MD 21801

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

30. Nema and address of person who completed causa ol daeth (Itam 23a) (Type, Print)

mD 32. Registrar's Signature

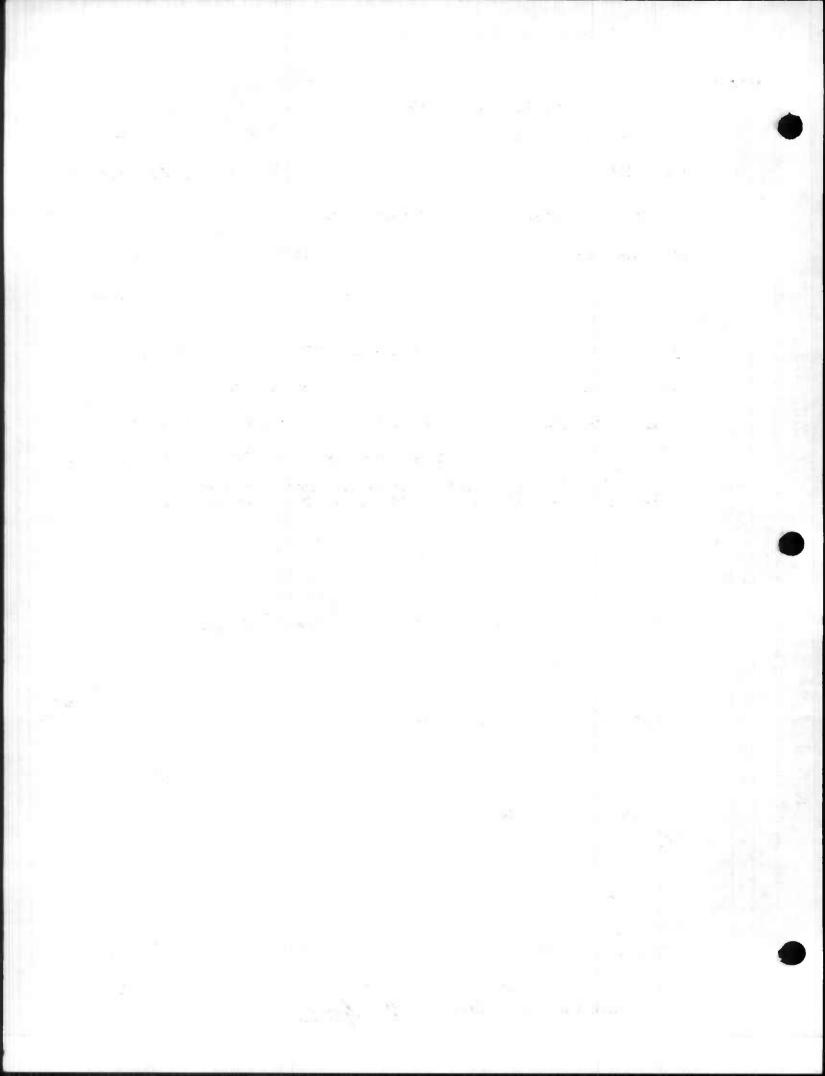
400 Eas Cer Shore Dr

State Registrar

filled in by

Medical

To the Hospital within 24 hours e To the Funeral C completely filled



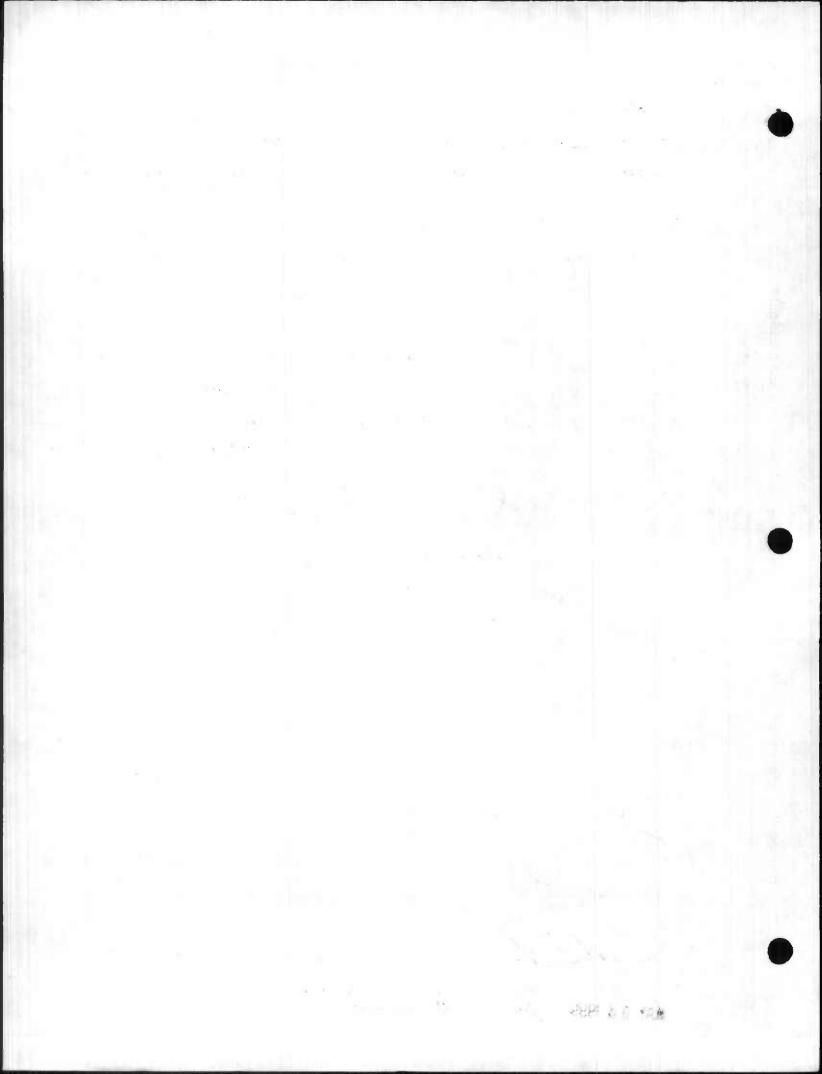
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First Middle Last) 2. Data of Death Month 3. Tima of Daath **Physician** ORVILLE S. THOMAS May 1, 6:57 A.M. /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Daath 4c. County of Death Examiner 319 Camden Avenue- Apt. D Salisbury Wicomico 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours 1XXM 2□ F Yrs 69 Director 226-32-2087 April 4, 1930 Virginia Usual Rasidance of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Wicomico Maryland Salisbury Yas 2 No Director 10a. Straat and Numbar 10f. Zip Coda 10g. Citizan of What Country? with 6 319 Camden Avenue - Apt. D 21801 U.S.A. items 23a death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. should be filed within 72 hours after ad Mental Hygiene. merked other than "natural", or ite 1 Nevar Married 2 Married 1 XYas 2 No Korean If Yes, Give Yaar or Datas: Conflic Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: White by 3 Widowed 4 Divorced Conflict Completed traumetic event, the Medical 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Waterman Seafood Tis mark 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) permit. Pages 1 and 2 should be.
Department of Health and Mental H.
Important: If them 27 is mark—
any injury or other—
once. Travis Thomas Susie E. Williams 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 319 Camden Ave. - Apt. D- Salisbury, MD Travis B. Thomas (Brother) 20b. Placa of Disposition (Nama of camatary, cramatory or other place)
American Legion Cemetery 20c. Location - City or Town, Stata Data 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 5/4/99 Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Nama and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immadiata Causa (Fina) MINS disaasa or condition resulting in daath) Examiner Examiner MTAS Comac physician end the buriel-transit The law requires that the death certificate be executed Saquantially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last to (or as a consequence of) Box 68760 Physician/Medicai Dua to (or as a consequence of) 80 esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 thknown þ Records, Completed 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? director, page 2 1□ Yas 2 700 1 Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this certifica stelly filled in by the funeral director, t Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1 Yas 2 No Certification: To 28a. Data of injury (Month, Day Year) 27, Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datermined 3 Suicida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner statad. 29a. Certifiar edical (Check only one) 29b. Signatura and titla of cartifiar 29c. License numbar 29d. Date signed (Month, Day, Year) Srule M. Crun Mo 30. Nama and addrass of person who completed causa of death (Item 23a) (Typa, Print) 400 Castem Dine Suive Salin Md Wood, DONALD MD 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 5 1999

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veal **Physician** 1999 FRANCES VICKERS May 1 00:25 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil E1kton County If Linder 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Min. Hours Months 1□ M 21 F Yrs 82 Director 218-32-9725 December 1, 1916 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits mast be notified at 1 Yes 2 No Director Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flerna 23a 48 Bayside Drive Funeral 21901 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus the Medical Examiner Black, White, etc. shar 1 Never Merried 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 aboud be fised with Department of Health and Mental Hygen important: If them 27 is marked other than any Injury or other traumatic event the 3 Homemaker Her own home 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Father's Neme (First, Middle, Last) Be James Garfield Montgomery Rosetta Phillips 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Abe H. Vickers / Spouse 48 Bayside Drive, North East, MD 21901 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 4 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 1999 North East, Maryland North East Methodist Cem. 21. Signature of Pitheral Service-Efferyl 22. Name and Address of Facility
Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical MALNUTR, MON Examiner Due to (or as a consequence of) Examine physician and the burial-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 88 080 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? paga 2 s has 1 Yes 2 DING 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Department 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation or Attending 1 Postural after death. Director: Aft 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. edicai 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only 29b. Signeture end title of cartily 29c. License number 29d. Date signed (Month, Day, Year) D - 32395May 3, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Finucan, M.D., 3 Mauldin Avenue, North East, MD 21901 32. Registrar's Signature 31. Date filed (Month, Day, Year)
MAY 0 4 1999 State Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician April 25, Wilbur Alfred Weller /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs. 6. Sex. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Oct. 18, 1923 Director Maryland 214-20-1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28a-f ahow 1 Yes 2 No Directo Maryland | Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Ave 21784 U.S.A. "natural", or Items 23a 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours efter Hygiens. Wher then "natural", or he 1 Never Married 2 Merried Specify: White Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: If Yes, Give WWII à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wh Department of Heelth and Mental Hyglens Important: if Itam 27 is marked other tha eny injury or other treumatic avent, that page. TV/radio Repair 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) B Carroll William Weller Helena Otto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 950 Ruby Dr. Carroll W. Weller/brother Westminster, Md. 21157 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation Inc. 4/27/99 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses 310 Church St. New Windsor, Md. 21776 23a. Part1. Enter the disease, or complications that caused and deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart tailure. List only one cause on each interest. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Finel 2day Accident · cerebrovascular disease or condition resulting in death) Examiner Due to (or es a consequence of) Physician/Medical Examiner attending physicien end of for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Hypertension by Completed 24a. Wes en autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 8 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No this Division of After thi 28b. Time of 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

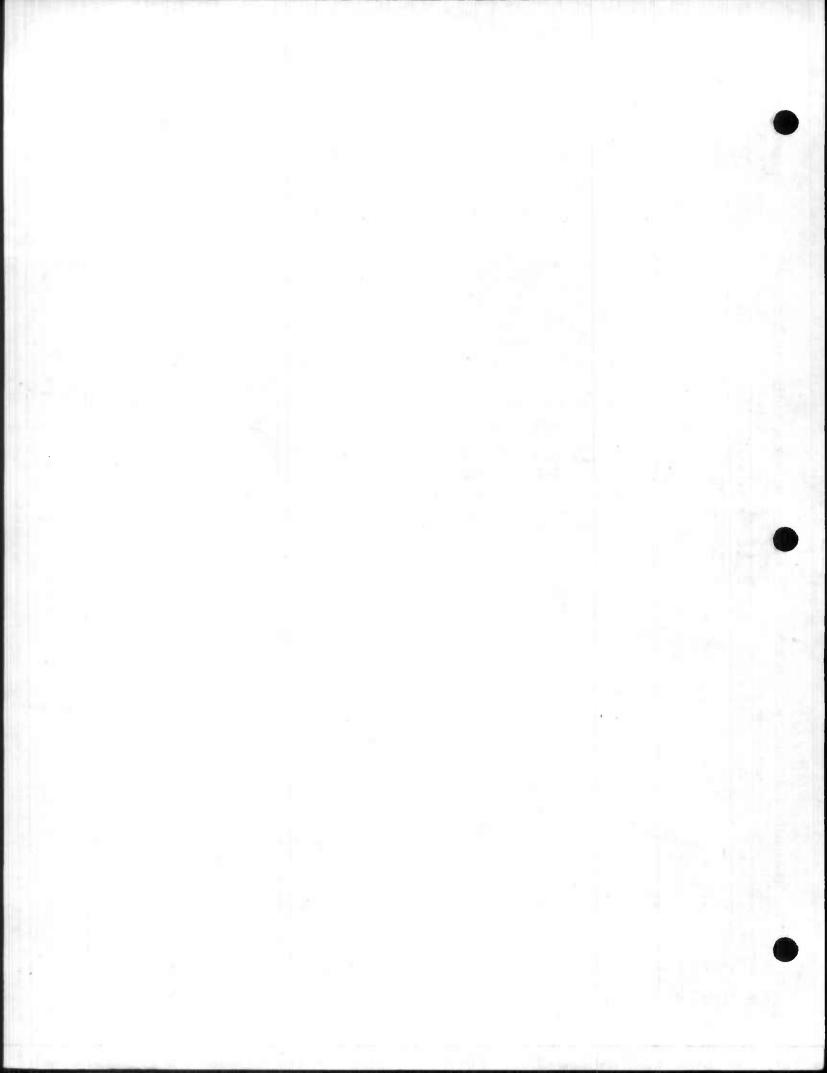
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April, 25, 1999 D 52479 Kim, m.O. 30. Name and stress of person who completed cause of death (Item 23a) (Type, Print) LISA KTM, M.D., at Carroll County General memorial Avenue, Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

APR 2 9 1999

Sparker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Amerided Item 3 Certificate of Death 5/3/99, bam Cecil Co.

1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Bruce P. Woodrow 1999 April 10:30 pm /Medical 4a. Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Daeth 4c. County of Deeth Examiner Sunrise Care & Rehabilitation Center Elkton Cecil If Under 1 Yaar 5. Sociel Security Number If Undar 24 Hrs. 8. Date of Birth (Month, Dey,) July 19, 7. Age (In yrs. lest birthday) Birthplece (State or Foraign Country) **Funeral** 1**X**0 M 2□ F Months Days Hours Yrs. 716-01-6246 1907 Pennsylvania Director Usual Rasidance of Decedant the Maryland 10e. Stata Show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 XYes 2 □ No Director 28a-f Maryland Cecil Risina Sun 10e. Straat end Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 402 Pearl St. 21911 USA death 12. Was Decedent Ever in U,S. Armad Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Datas: 11 Meritei Stetus Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indien Bleck, White, etc. within 72 hours after 1 ☐ Never Married 2 Marriad Baltimore, Maryland 21215-0020 naturaf, or 1 ☐ Yas 2 X No Specify: by 3 Widowed 4 Divorcad White Completed 15. Decadent's Education 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa ratired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, it is Ma Elamantery/Sacondary (0-12) Collaga (1-4or 5+) 9 Train Dispatcher Railroad 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumame) Be Lo Thomas Woodrow Florence Patton 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) Chris Walk 530 E. Oak St. Palmyra, PA 17078 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20e. Method of Disposition 20c. Locetion - City or Town, State Dete 1 ₺ Burlel 2 □ Cremation 3 □ Removal from State 5-3-99 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Chapel Cemetery Conowingo, Maryland 21. Signeture gLEuneral Service Licensee 22. Name end Addrass of Facility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 Do not enter the mode of dying, such as cerdiac or respiratory errest. 23a. Part I Enter the disease, of complete shock, or heart failure. List only one Approximate Intervel Between Onset and Death Physician Immediate Causa (Final disease in condition resulting in small) /Medical Examiner LAR ACCIPENT Examiner The law requires that the death certificate be executed the bunal-transit Sequantially list conditions, if eny, leeding to immediate ceuse. Entar Underlying Causa (Diseese or Injury that initieted evants resulting in death) Lest Box 68760. Physician/Medicai Due to (or es e consequança of) use as for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ρ 24b. Were eutopsy findings aveileble prior to completion of causa of death? page 2 should Completed 24a. Wes en eutopsy parformed? 2 No 1 ☐ Yas Division of Vital Be 25. Was cese refarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Ves 2 No Other: Nursing Homa 5 - Rasidence 6 - Othar (Specify) Certification: To this 27. Mannar of Deeth Date of Injury (Month, Dev Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturel
2 Accidant or Attending 5 Panding Invastigation Injury s aftar death.
I Diractor: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Spacify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida within 24 hours a To the Funeral D Hospital Pelli Medical 29a. Certifier 🗠 Certifying Phyalcian: To tha best of my knowledge, deeth occurred at tha time, dete end plece, end dua to the ceuse(s) and mannar as stated. completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and mennar stated. (Check only one) To tha 29b. Signatura and titla of certifig 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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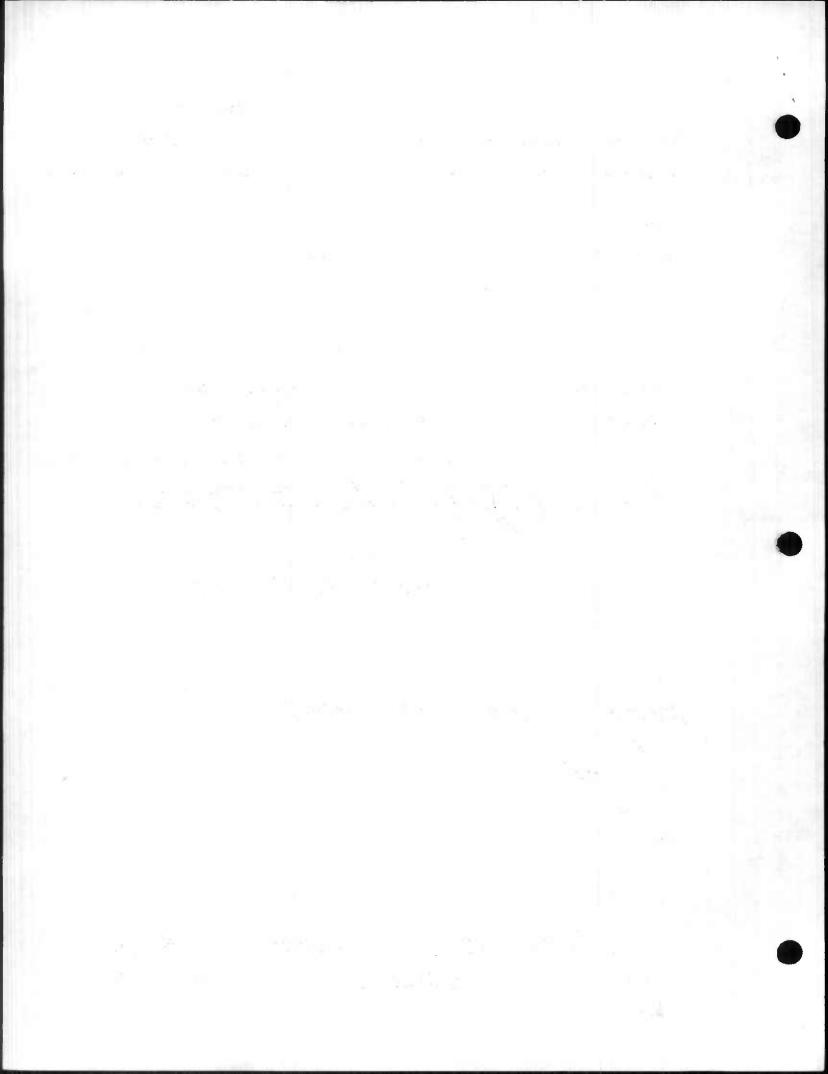
30. Name and address of person who complated ceusa of deeth (Item 23a) (Type, Print)

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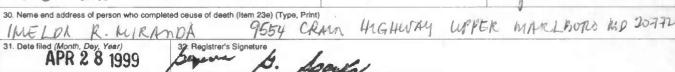


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/Medical Examiner	4e Fecility Neme (If no Southern Ma	ot Institution, give	street end number	r)				4b.	City, Town, or L	ocation of Deet				
Funeral Director	5. Social Security Num 220-26-6851		7. A	ige (In yrs.	lest birth	A	If Under 1 Y Months De	ear eys	If Under 24 Hrs. Hours Min.	8. Dete of Bir Apr 1 1	th Y 1931		plece (State or Foreign (P) Tand	
how	Usual Residence of De 10a. State 1	ecedent 0b. County		10c. Cit	y, Town	or Loca	tion						10d. Inside City Limits	
ctor	Maryland F	Prince Geor	rge's			l	Jpper M	arlb	oro				Yes 2□No	
3a or 2	10e. Street end Number 12825 Town	er n Center Wa	ду				10f. Zip Co		0772		10g. Citizen of Whet Country? U.S.A.			
Department of the substitution of the wing the way and population of the substitution	11. Marital Stetus 1 Never Married 3 Widowed 4		12. Wes Decedent Armed Forces 1 Yes 20 If Yes, Give Yeer or Detes	? (No	,S.		s Decedent es, specify (t of Hispenic Origin? (Specify Yes or No- Cuben, Mexicen, Puerto Rican, etc.) No Specify:			14. Rec Bled Specify	cen Indien, , etc.		
ygiena. her than "natura nt, the Medical		5. Decedent's Edu only highest gred					d of work de	one du	ion ring most of wor	king	16b. Kind of Bu	ısiness/ir	ndustry	
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Mental Hyginarian Mental Hygin	17. Fether's Neme (Fin		orbes		18. Mother's Neme (First, Mi Rebecca						, Maiden Sumem			
th and M	19a. Informent's Ne <i>me/</i> Reletionship (<i>Type, Print</i>) Miss Joyce A. Washington (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11011 Woodlawn Blvd. Upper Marlboro, Maryland 20772													
ant of Hear in y or other	20e. Method of Dispos	Cremetion 3 □R	emoval from State	C	emetery	creme	ion (Neme of tory or other MONY M	r piece)	ial Park	Dete 5/1/99	20c. Location -			
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

31. Dete filed (Month, Dey, Year) APR 2 8 1999 State Registrar



Minade ; M. D

29c. License number 0 4 32 7 6

29d. Date signed (Month, Dey, Year)

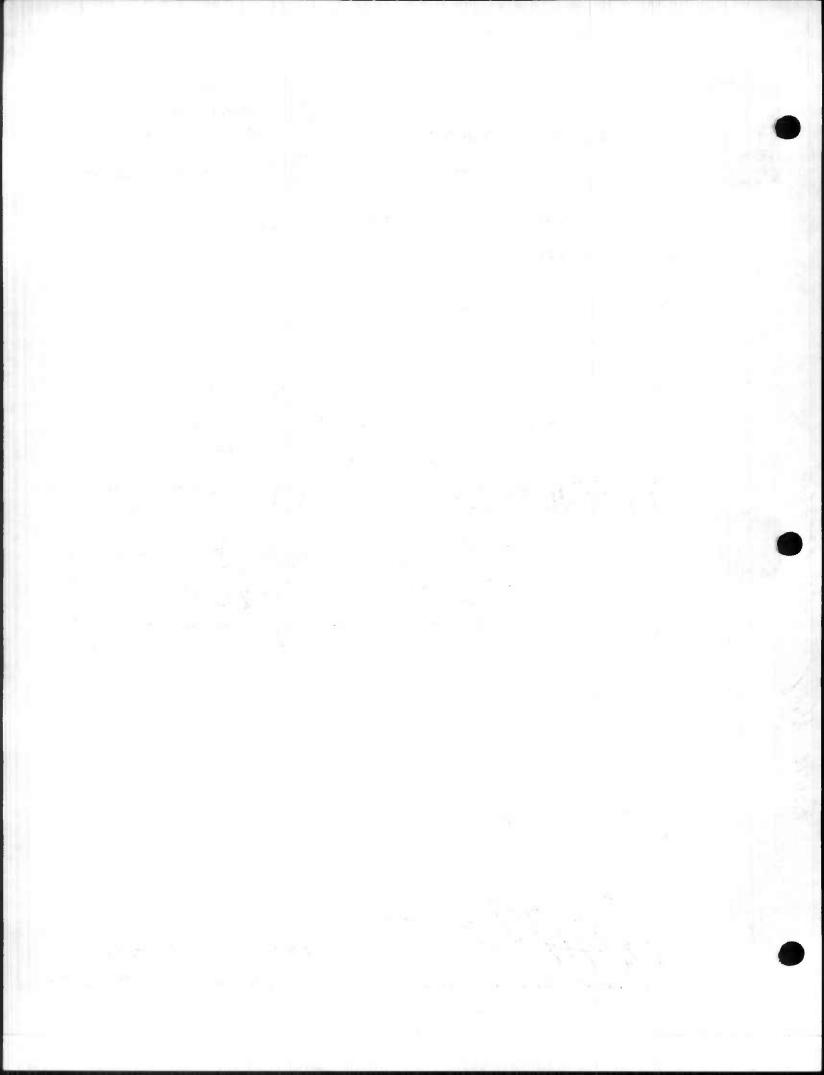
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THE SHAFE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of IV	iaryianu / Dep Ce	ertificate of			Reg. No.	9	5579
	Physici	an	1. Decedent's Name (First, Middle, L.	*	U			2. Data of Dea		Year	3. Time of Death
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	Funeral Director		5. Social Sacurity Number 6. 108–22–4766 Usual Residence of Decedent	Sax 7. A 1 🔀 M 2 🗆 F	ge (In yrs. last birthda) 77 Yrs.	Months Days		8. Data of Birt (Month, Day July 14,	h v. Year) 1921	9. Birthpie Counti New	ece (State or Foreign ry) York
	yland		10a. State 10b. County		10c. City, Town or I	_ocation				10	d. inside City Limits
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Maryland 21215-0020	hin 72 hours s. in "neturel", Medical Ext	Completed	15. Decedent's E (Specify only highast gr Elementery/Secondery (0-12)	ducation ada completed)	16e. Dec (Giv life.	edent's Usuel Occu a kind of work done DO NOT use retire	petion during most of work ed)	sing	16b. Kind of B	usiness/indu	istry
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ary	2 should be end Mente is merked sumetic ev	To	19e. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Stree	t end Number or Rur	ral Route Numbe	r, City or Town,	State, Zip (Code)
	s 1 end 2 s f Health er ftem 27 is other trau		Ethel Isaacs/Dau	ighter			6, Willar	ds, MD	21874		
Baltimore,	ges F it of or o		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			position (Name of ematory or other pla y Cremato	1 /	Data 1/26/99	20c. Location -		
alti	Party Sparts		21. Signature of Euparal Service Lice	risee	alogi.	22. Name and Addre	ess of Facility				
ш	Per Ing		Marie &	nomo	200	501 Snow	Funeral He Hill Rd.,	Salisbu	irv. MD		
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or conshock, or heart feilure. List only Immediate Cause (Finel disease or condition resulting in death)	e. R	Due to (or as a confe	Yen?	hus.	- A-	- 1/2 /L	~~~	Approximate Intervel Between Onset end Death
Box 68760,	death certificate be executed e ettending physicien and of for use as the bunel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	c. C	Due to (or as a conse	equanca of):	rtez	X.	sect	-	3-
P.O. B	y th	Physician/M	Part II. Other algnificant conditions	contributing to death t	out not resulting in the	underlying cause gi	iven in Pert I.		obacco use co		the cause of death?
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Records,		Completed						24a. Was perfo	an autopsy med?	aval	re autopsy findings lable prior to apletion of ceusa eeth?
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	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Medicai C	29a. Certifier (Check only one) 1 Cartifying Pl 2 Madical Exa	nyalclan: To the best miner on the basis of anomaryier st	of my knowledge, dea of examination end/or leated.	th occurred at the ti nvestigetion, in my	ime, date and place, opinion, death occur	and due to the ored at the time,	causa(s) and mi date and plece,	annar es sta and due to	ted. the cause(s)
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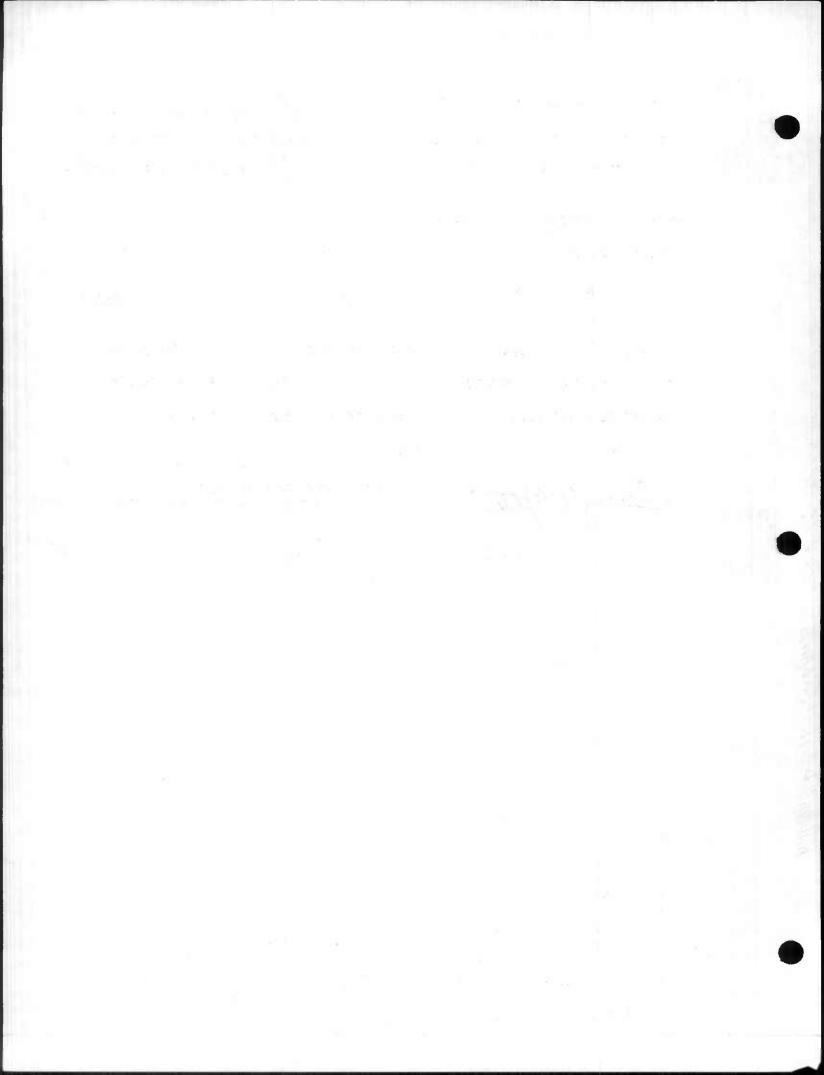


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month WILLIAM DAVID WETHERHOLD, SR. 1210 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplece (State or Fore APRIL 28, 1916 | PENNSYLVANIA If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 10XM 2□F Days 164-07-3205 82 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits ral", or items 23a or 28a-f show 1 ☐ Yes 2 No Director DELAWARE SUSSEX SEAFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RT. 4, BOX 175 19973 AMERICA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yes, Give Yaar or Dates: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Spacify: natural, or Specify: WHITE þ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry be filed within 7 sel Hygiene. Elementery/Secondary (0-12) 12 yrs. College (1-4or 5+) 2 yrs. SCHEDULING CLERK MANUFACTION permit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) FLORENCE MOYER WETHERHOLD WILLIAM RHOENOEL WETHERHOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) GLADYS M. WETHERHOLD RT 4 BOX 175 SEAFORD, DELAWARE 19973 20a. Method of Disposition 20b. Placa of Disposition (Neme of 20c. Location - City or Town, State EASTERN SHORE 1 ☐ Burial 2 Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/99 LEWES, DELAWARE CREMATORIUM of Funeral Service Licenses 22. Name and Address of Facility WATSON-YATES FUNERAL HOME, INC fions that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, cause on each line. SEAFORD, DELAWARE 19973 ther the disease, or complicate heart failure List only on Approximate Interval Betwe Onset and Death **Physician** /Medical Immediata Cause (Final arec Metostatic CIR Y' diseasa or condition resulting in deeth) Examine Due to (or es e consequence of) sician end buriel-transit Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1) Yes 2 No 3 Probably 4 Unknown Records, ð Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 No Division of Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28f, Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner states. 29a. Certifier Medical (Check only one) ŝ 29c. Licansa number 29d. Data signed (Month, Day, Year) 10 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Carroll St Solish, MB E. Conall, MD 145 E. 31. Data filad (Month, Day, Year) 32. Registrar's Signature State APR 2 6 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dey **Physician JOHN** April 24, HENRY 1999 WRIGHT 10:55 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 630 Ridge Rd. Salisbury Wicomico If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Min. Days Months 1⊠M 2□ F Hours 235-52-6980 64 Director November 27,1934 West Virginia Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Medical Examiner must be notified at 10d. Inside City Limits Maryland Wicomico 1X Yes 2 □ No Salisbury Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 630 Ridge Rd. 21801 USA Funeral death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Was Decedent Ever in U,S. Armed Forces? Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter. Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or ite, any Injury or other traumatic event, the Madical Examples. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 White Specify: þ 3 ☐ Widowed 4 X Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Iron Industry Steel Worker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Arthur E. Wright Georgia Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John H. Wright Jr./Son 14572 Foltz Dr., Eden, MD 21822 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4/26/99 Salisbury, MD Salisbury Crematory
22. Name end Address of Fecility 4 ☐ Donetion 5 Other (Specify) of Funanti Service License Holloway Funeral Home Professional Association 62 501 Snow Hill Rd., Salisbury, MD 21804 Enter the disease, or complications that caused the math. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final CONGESTIVE HEART FAILURE disease or condition resulting in death) Examiner Examiner ESEVERE LY DYSFUNCTION CARDIOMYOPATHY certificate be executed ettending physician and for use es the bunel-transit Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated average) HYPERTENSIVE HEART DISEASE Box 68760 Physiclan/Medical that initiated events resulting in death) Last Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. ed by the e 23b. Did tobacco use contribute to the cause of deeth? P.O. been signed by should be detec 3 Probably 4 Unknown CHRONIC RENAL FAILURE 1 ☐ Yes 2 ☐ No Records, þ 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of deeth? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpetient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Certification: After 5 Pending investigation 1 Natural 1 | Yes 2 | No death. 2 Accident or Attend efter death Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral Certifying Phyalcien: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only onel

29d. Date signed (Month, Dey, Year)

Drive

State Registrar 29b. Signature and title of certifier

31. Date filed (M

MD

32. Registrar's Signature

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my 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene C

Certificate of Death

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Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician VIOLET AMELIA WASHINGTON APRIL 30,1999 01:10 am /Medical 4b. City, Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
if Under 24 Hrs. 8, Date MONTGOMERY 8. Date of Birth MAR. Dey, Year) 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
9 MD. 5. Sociel Security Number **Funeral** Months Days Min 1 M 2 F Hours 220-30-9525 Director Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at MONTGOMERY V☐ Yes 2 No MD. Director ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 914 N. STONE STREET AVE. 20850 U.S.A. Funeral filed within 72 hours after death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Biack, White, etc. 7 is marked other than "natural", or items traumatic avent, the Wed cal Example: m 12. Wes Decedent Ever in U.S. 11. Maritei Stetus 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: BLACK by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MONT. CO. SCH. Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. SYSTEM TEACHER 10 TH 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) . Pages 1 and 2 should be file iment of Health and Mental He lant; if Item 27 is marked oth jury or other traumatic aven Be OGLE LESTER SEWELL MARGUERITE BROWN 19b. Meiling Address (Street and Number or Rurel Route Number, City or Touth, Prate, Z. 0005 0 19a. informant's Name/Relationship (Type, Print) JOCELYN A. WASHINGTON (DAU.) 914 N. STONE STREET AVE. ROCKVILLE 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery crematory or other place)
RESTHAVEN MEM. Mariai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GAR. MAY 6,1999 FRED. MD. permit. Page Department of Important: If any Injury or 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 21701 GARY L. ROLLINS FUNERAL HOME X. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervel Between Consett and Deeth Consett and Deet Physician Immediate Cause (Final diseasa or condition resulting in death) Cor sulmonal /Medical Mouths Examiner dispers syndrome Examiner ician and burial-transit Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest the death certificate be exec physician sthe burial Box 68760. Physiclan/Medicai Due to (or as a consequence of): attending pl signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2/ No 3 Probably 4 Unknown 1 Yee ρΛ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 168 2/1 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturei 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28a. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signeture and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROVE RD ROCICULE M

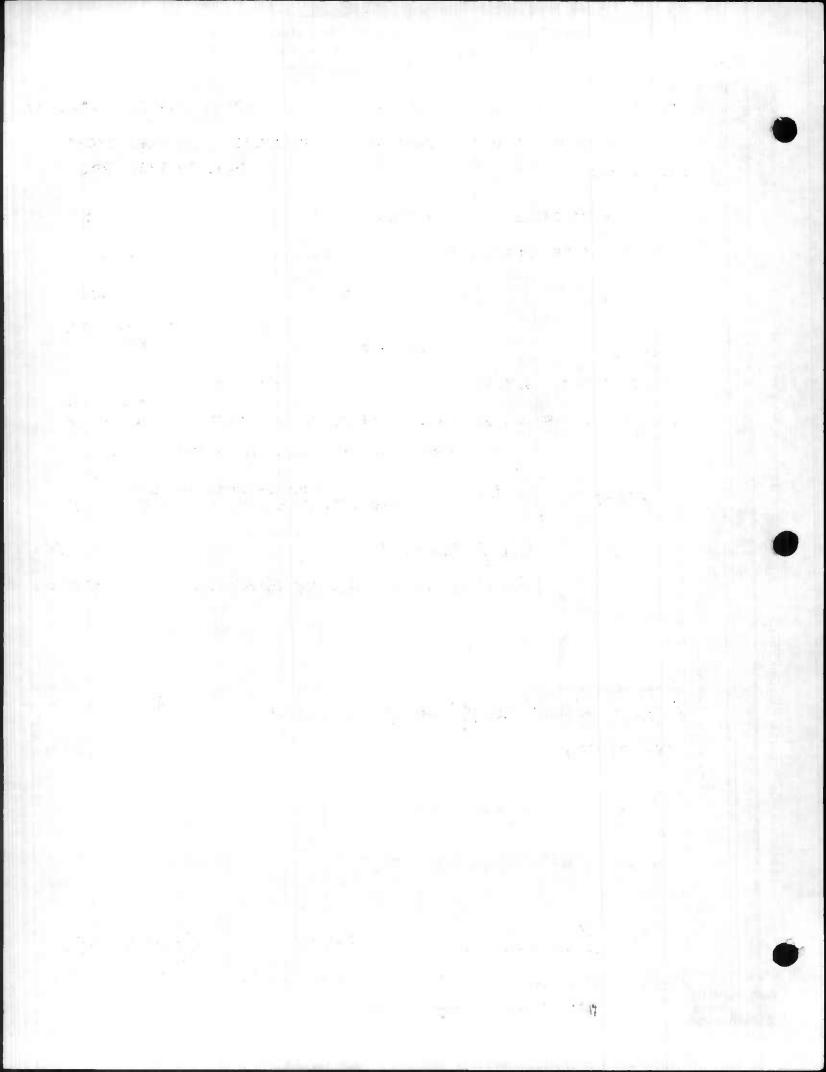
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Registrar

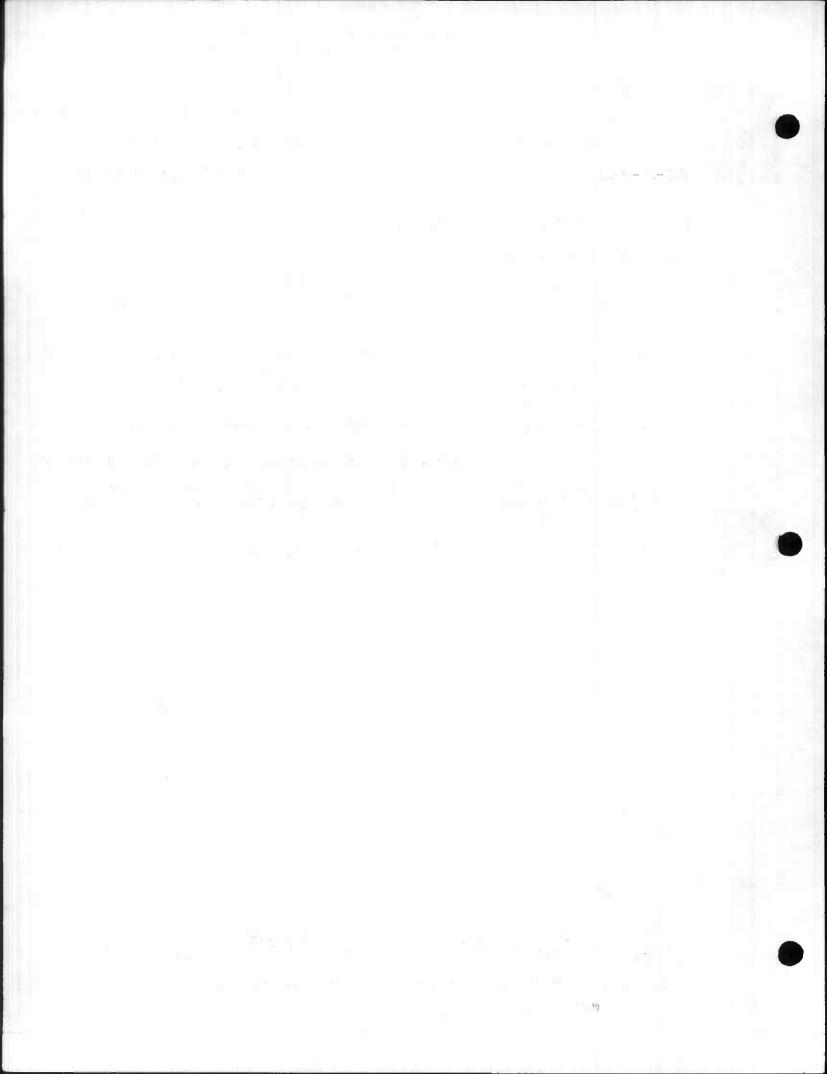


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900	29b.	Signatura and	title certifier	0		~				number			29d. Data sign	ned (Month,	Day, Year)		
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_	2 (ulaw MD D 22037 April 30, 1999																
2	30. N	30. Name and address of person who complated cause of deeth (Item 23e) (Type, Print)															
	30. N	ame and addr	ass of person w	no comp	ated cause	of deeth (Ite	m 23e) (Tyl	pe, Print) , Brunst	vicl	k, Ma	ryla	nd 21	_				
Medical Certification: To Be		ama and address	INC	AN.	₹ 610	9th A	venue	, Brunsw		k, Ma		nd 21	_				

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yee **Physician** MADELINE L. YOUNG 1999 April 24 11:50 a.m. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner WALDORF HEALTH CARE CENTER WALDORF CHARLES COUNTY if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F Vrs Director 215-44-9499 May 12, 1921 Maryland Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified and 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Director Washington D.C. 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 1702 Minnesota Ave S.E. #2 20020 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No f Yes, Give 1 Yes 2 No Specify: Specify: Black P 3 ₩ Widowed 4 Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 9th Homemaker Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Redgley Scott Annie Mundell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Betty Jennings (daughter) 2713 Fairlawn Street Temple Hills, MD 20748 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donelion 5 ☐ Other (Specify) Washington National Cem. 4-29 Suitland, Maryland 22. Name end Address of Facility MARSHALL 'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licenses · lonuc 4308 Suitland Road Suitland, Maryland 20746 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting In death) METASTATIC CANCER OF LUNG MONTHS Examine Due to (or es e consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medicai Due to (or es e consequence of) attending for use as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records. P. RENAL FAILURE þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? should I 24a. Wes en eutopsy Completed his certificate has but director, page 2 sl 1 Yes 2 No 1 TYes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dele of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? : After 5 Pending 1 X Neturel 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu death. 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. edicai 29e. Certifier (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and tall 29d. Date signed (Month, Day, Year) 29c. License number April 26, 1999 no completed cause of deeth (Item 23e) (Type, Print) 30. Name and eddress of person Howard M. Haft, M.D. 12070 Old Line Centre, Suite 100 Waldorf, Maryland 20602

State Registrar 31. Date filed (Month, Dev. Year) APR 2 7 1999

Registrer's Signature

848 . V 1. V

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Day 23 **Physician** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Holy Cross Rehab. And Nursing Center Burtonsville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-13-25 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days M 2□ F Hours Min 74 Yes 551-79-4231 Director India Usual Rasidence of Decedent with the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumetic svent, the Medical Examiner must be notified at 1 Yes 2 No MD. Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3505 Olive Branch Dr. USA 20904 Funeral death 14. Race - American indian. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Haalth and Mental Hyglena. Important: If item 27 is marked other than "naturef", or item any injury or other treumetic event, the Medical Emirine Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Asian þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Shoes Sales Manager - Degree 17 Father's Name (First Middle I ast) 18. Mother's Name (First, Middle, Maiden Surname) Be Asghar Hussain Zaidi Hashmat Begum 19a, Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Shameem - Son 350501ive Branch Dr, Silver Spring, Md. 20904 Mohammed 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 4-23-99 Laurel, Md. Maryland Memo. Park 22. Name and Address of Facility Universal Mortuary Inc. 21 Sanature o Funeral Service Licenses 411 Kennedy St, N.W., Washington, D.C. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, hock, or heart failure. List only one ceuse on each line. **Physician** /Medicai Immediate Cause (Final diseasa or condition resulting In death) Examiner Examiner Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last pue buriel-tran Due to (or as a consequence of): certificete be axec P.O. Box 68760. physician Physician/Medical the Due to (or as a consequence of) SB attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an eutopsy peed performed' pege 2 has 1 TYes 2 7 No 1 Yes 20 No this certificate Division of Vital Attending Physician: director, Be 25. Wes case referred to medice 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: Aftar 5 Pending Investigation 1 Netural Injury ie Hospital or Attending n 24 hours after death. ne Funeral Director: Aft 1 Yes 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) To the F within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Wheaton 2309 Shoredie Shumache 31. Date filed (Month, Day, Year) APR 2 7 1999 State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** 1999 710 RANDALL BARHAM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HEALTH CARE AGNES Wours | Min. | 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) ùOM 2□F Months Days Yrs. 229-05-2440 81 N.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. N/A TY Yes 2 No BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4013 WOODHAVEN 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK g 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-LABORER STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) FRED R. BARHAM LILLIE MAE HOSKIN 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) KATHLEEN BARHAM(WIFE) 4013 WOODHAVEN BALTIMORE, MARYLAND 21216 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 5-12-99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 FSD artika 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE CARDIOVASCULAR Due to (or as a consequence of). Examiner SEPSIS 2 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ACUTE RENAL FAILURE 2 WEGKS Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 ⊠Unknown NEPHROTIC SYNDROME ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To ty⊈Inpatient 2□ ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of continue 29c. License number 29d. Date signed (Month, Day, Year) P12594 MAY 6

NAME

Division of Vital Records, P.O. Box

State Registrar

Funeral

Director

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Department Copartment of Important: If any Injury or once.

Physician

/Medical

Examiner

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21215-0020

Maryland

Baltimore,

31. Date filed (Month, Day, Year)

VAMES

32. Registian's Signeture MAY 12 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

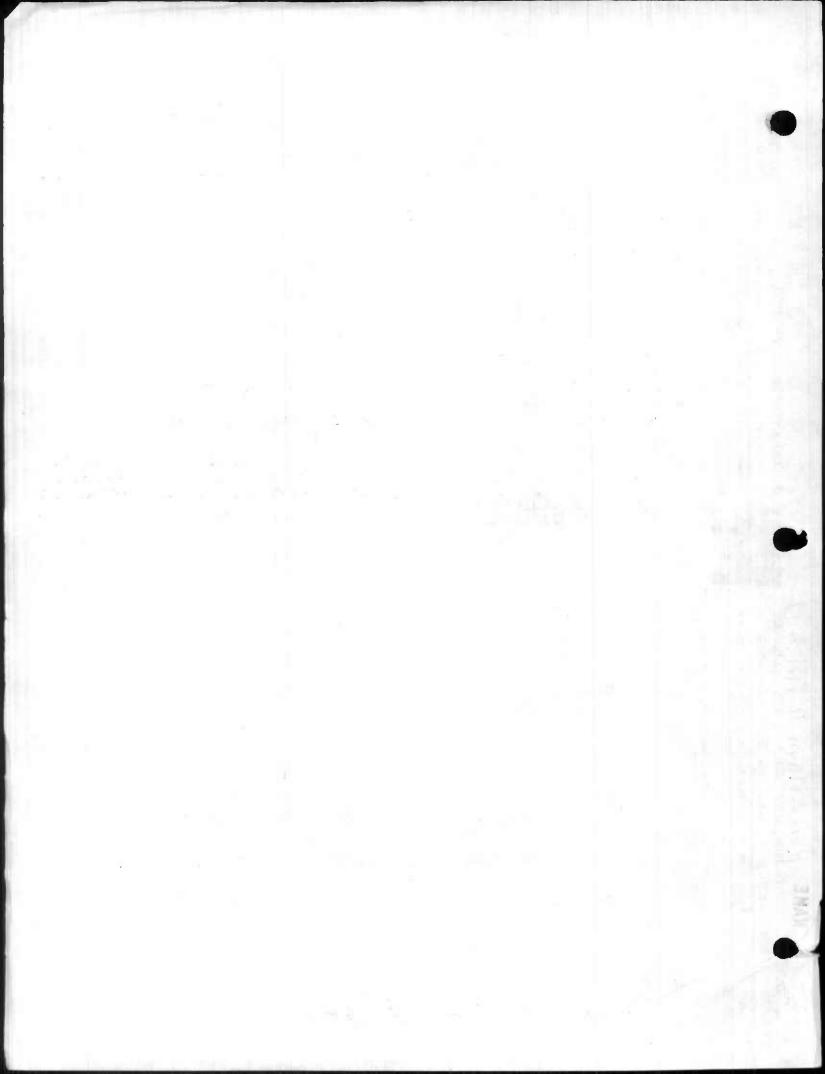
LACEY, MD

ST AGNES HEALTH CARE 900 CATON AVE BALTIMORE, MD 21729

death.

Diractor:

To the Hospital within 24 hours a To the Funeral Completaly filled



WRC 99-2651-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. DARRYL E. State of Maryland / Department of Health and Mental Hygiene BOND (UNK 99-097) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month MAY Day **Physician** 09, 1999 3:35 PM. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4802 REISTERSTOWN RD. BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stateyor Foraign **Funeral** Days 10 M 20 F 219-80-14 Usual Residence of Decedent Yes Director 10b. County 10a. State Town or Location 10d. Inside City Limits must be notified at 1 Yas 2 No Director mor 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 212 Funeral 14. Race - Amarican Indian, Was Decedent Every Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Name 11 Marital Status in U.S Black, White filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed): 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ue. 0 ather's Name (First, Middle, Last) ther's Name (First, Middle, Maiden Surname) 18. M Be h and Mental h 8 Pages 1 and 2 should MUR ORIA r Town, Staye, Zip Code) 2/208 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Revite Number, City nt of Health a ORI 20a. Method of Disposition 20b. Place of Disposition (Name of or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenti 0 mondson 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of shock, or heart leilure. List only one cause on each the complete the mode of shock, or heart leilure. dying, such as cardiac or respiratory Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 1 Yas 2 No 2∏ No Yas Division of Vital 25. Was case referred to medical examiner?

1kd Yes 2 □ No To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of tnjury 27. Menner of Death 28e. Dete of tnjury (Month, Day Year) 28d. Describe how injury occurred Medical Certification: 28c. Injury et Work? After or Attanding 5 Panding investigation 1 Netural Subject Famel 5/9/99 Short 1530HRS 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4802 Persturion 28e. Place of thiury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide dwell Ma lang Lorge

n 24 hours after death.

The Funeral Director: After pletely filled in by the fur Hospital To the Hosp within 24 hor To the Fune completely fi

> State Registrar

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HEDDORE 31. Date filed (Month, Day, Year) MAY 12 19

29e. Certifier

(Check only

29b. Signature and title of cartifie

111 Penn Street, Baltimore, Maryland 21201 MIKING 82. Registrar's Signatury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Na

Certifying Physician: To the best of my knowledge, death accounted at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

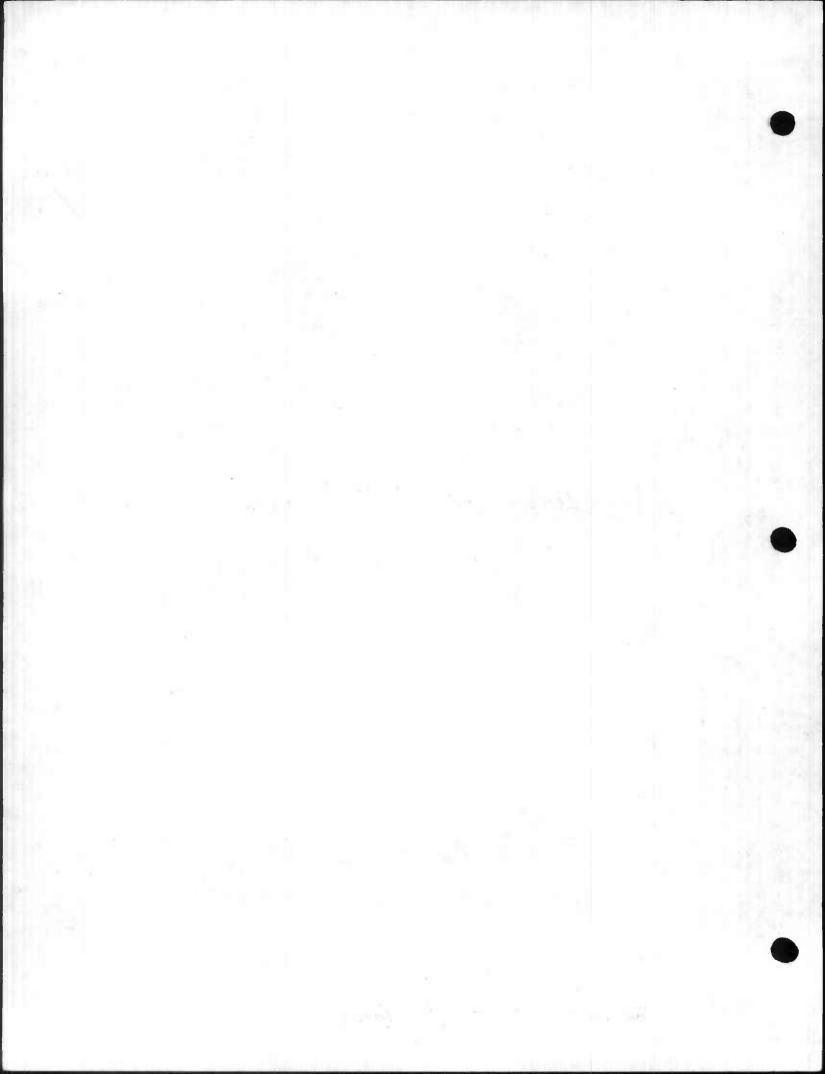
29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

10, 1999

MAY



State of Maryland / Department of Health and Mental Hygiene

			C	Certificate of Death	R	leg. No.	15588
			Dacedant's Name (First, Middla, Last)		2. Dete of Dee	th	3. Tima of Death
	Physici /Medio		CHARLOTTE RUSSELL BARNETT		MAY 11,	1999 Year	12:15PM
3	Examir		4e. Facility Neme (if not institution, giva street and number)	4b. City, Town, or Lo	ocation of Death	4c. County of De	ath
			PICKERSGILL RETIREMENT COMMUNITY	TOWSON		BALTIMOR	RE
	Funeral Director		5. Social Security Number 199-36-4191 Usuel Rasidanca of Decedant	Months Dave Hours Min	8. Data of Birth (Month, Day MARCH 30,		rthplace (Stata or Foraign country) nington D.C.
	show		10e. Stete 10b. County 10c. City, Town of	r Location			10d. Insida City Limits
	8a-f	cto	Maryland Baltimore Towson				1 □ Yas 2 XXIO
	th with the 23a or 2	Funeral Director	10e. Street and Number 615 Chestnut Avenue	10f. Zip Coda 21204	1	USA	ountry?
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylend Department of Heelth end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show stripluty or other treumatic event, the Medical Examinat Instituted and page.	by	1 Never Marriad 2 Married 1 1 Yas 2 1 1 No 1 No 1 No 1 No 1 No 1 No 1 No	13. Was Dacedant of Hispanic OrIgin? (Sp If Yas, specify Cuban, Mexican, Puarto 1 ☐ Yes \(\frac{\text{X}}{\text{No}}\) No Spacity:	ecify Yas or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
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and	be fill d out	Be	17. Fathar's Nama (First, Middle, Last) Edwin Allen Russell	18. Mothar's Nam		•	
Ž	should and Men marke umatic	T _o			Page Ma		
Ma	d2 st th end 7 is n treun			leiling Address (Street and Number or Rur			
e,	1 and Heelth em 27		20a Method of Disposition 20b Place of D	Garrison Forest Ro	Deta Deta	20c. Location - City o	
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Ba	permit. Departrimports eny inje		21/Signature of Funeral Service Licensee	22. Name and Address of Facility Mit 6500 York Road Balt			
			23a. Part1. Enter the disaess, or complications that caused the deeth. Do not shock, or heart failure. List only one couse on each line.	enter tha moda of dying, such as cardiac	or raspiratory an	est,	Approximate
a	Physician						Onset and Deeth
И	/Medical		Immediata Causa (Final diseasa or condition	ive dement	ia		years
п	Examiner		rasulting in death) ato (or as a cor	nsequenca of):			
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687	ficete p physical as the	edical	resulting In deeth) Last Dua to (or as a con	sequance of):			
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m	0 0 0	sicia	Pert II. Other eignificant conditions contributing to death but not rasulting in the	na underlying causa given in Part I.	23b. Dld to	obacco use contribu	te to the cause of death?
P. O.	es thet the death ce igned by the ettend be deteched for us	Physician/			1 D Y	(Probably 4 ☐ Unknown
s,	gned be de	by F					
Records,	been s	Completed			24a, Was a perfor	n autopsy 24b med?	. Were autopsy findings availabta prior to completion of cause of deeth?
	The lev ite hes page 2	E O			1 🗆 Y	as 2 No	1 ☐ Yas 2 ☐ No
ita		Be	25. Was casa rafarred to medical axaminar?	26. Placa of Deat	h (Check only or	na)	
×	hysic il dire	70	1 ☐ Yes 2 O No Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing Ho	oma 5 🗆 Rasid	ance 8 □Othar (Sp	ecify)
Division of Vital	Attending Physicien: The Isr death. ector: After this certificate he by the funeral director, page		27. Mennar of Death 1 Natural 5 Panding 2 Accidant Investigation 28e. Data of Injury (Month, Day Year)		28d. Dascribe h	ow Injury occurred	
Divis	her differ Certification:	3 ☐ Suicide 6 ☐ Could not be datermined 28e. Ptace of trijury - At home, farm building, atc. (Specify)	, straat, factory, office	28f. Location (S City or Tow	treat and Number or F n, Stata)	Rural Routa Number,	
	To the Hospital or Alt within 24 hours effer of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Phyelclan: To the best of my knowledge, d (Check only one) 2 Medical Examinar: On the best of my knowledge, d	eath occurred et the tima, data and ptace, r Invastigation, In my opinion, daath occur	and dua to tha c	ausa(s) and mannar a lata and placa, and de	as stated. ua to tha cause(s)
	o the omple	Me	29b. Signature and title of certifler	29c. Licensa number		9d. Data signed (Mor	
	F 5 F 0		10 forthansteller	cup 225205	- 1	naul.	2, 1999
			30. Name and address of person who completed gruss of death (Itam 202) (Ty	rpe. Print)		1	
			W. A. Riley GBM (678) 31. Detecting of Mark Park 132. Registrar's Signature	pe, Print). Chale St.	Balt	o. Ind	5150%
	Sta Registr	_	MAY 13 1999 Serger S	Son VI			

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Physician /Medical	MARIE	CAROLI	NE BACI	KERT						MAY 8,	Day	Year	3. Time of Death 0827 AM		
Examiner	4e Facility Nama (If not 518 NORTH			7)				4b. City, Town, BALTIM		tion of Death	4c. County				
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Pu	Usual Rasidanca of Dec 10a. Stete 10b	edant . County		10c. Cit	y, Town or I	ocation						10	d. Inside City Limits		
death with the Manyland me 23a or 28e-f ahow must be notified at marai Director		N/A			BALT					1≹ Yes 2□					
fler death with the Ma ritems 23s or 28s-fa other must be notified	10e. Street and Number	N/A			DALI							Citizen of What Country?			
with with	518 N. CUR	TEV CTD	n n m					205							
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Marylar d 2 should be the and Mente T te marked treumetic av		RANK KLIMA MARGARET EBERLING Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town,										S			
Ma d 2 st d 2 st d 2 st f la n traur	DONALD P.														
	20a. Mathod of Dispositi		(2011)	20b. F	Place of Dist	nosition /A	lama of	CT., EI			20c. Location				
Baltimore, semit. Pages 1 ar Supartiment of Hea moortant: If them ny Injury or other inte	1 Burial 2 □ Cri 4 □ D Gution 5 □	emation 3		ZIC LU	amatary, cr ON EVA THERAN	NGEL CEM	ICAL ETER	а <i>се)</i> Ү					ARYLAND		
Ball permit Depart import any lot once.	21. Signature of Funeral	Service Lidens	00)		1 5	SCHIM	UNEK	rass of Fecility FUNERAL MS LANE				ZLAND	21213		
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	rasuling in Gealin, Cast											1			
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O. Bo death he atter ed for u	Pert II. Other significant	conditions cor	ntributing to death I	but not ras	ulting in the	underlying	cause g	iven in Pert I.		23b. Did to	bacco use co	entribute to	the cause of death		
is, P.O. B es that the death igned by the attended for be detached for by Physicia										1 🗆 Ye	18 38 No	3 Probe	ably 4 Unknow		
Sording Personal Should										24a. Was ar perform	ned?	com	re autopsy findings ilable prior to apletion of cause		
The law rate has page 2										L/Mi1	s 2□No		éath? Yes 2□ No		
Vitai I	25. Was casa rafarrad to	medical						26. Placa of	Death (Check only on	a)				
Of Vita Physician: this certific ral director,	axaminar? XXX Yas 2 □ No	F	lospital:	ient 2 🗆	ER/Outpation	ent 3	DOA O	ther		Reside		ner (Specify))		
	27. Mannar of Death 1.20 Natural 5 [2 Accidant	Panding invastigation	28a. Data of Inj (Month, D	ury ay Year)	28b. Tima Injury	of M	28c. Inj W			d. Describe ho					
Division of all or Attending P after deeth. I Director: Attert of in by the funers of in by the funers certification:	3 Suicide 6 C	2 Accidant invastigation 3 Suicide 6 Could not be		28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)					28f. Location (Street and Number or Rural Routa Number, City or Town, State)						

6

State Registrar Stephen S. R.
31. Data flied (Month, Day, Year)

29a. Certifier



30. Nama and address of person who completed causa of death (Jem 23a) (Type, Print)

B. Sparks

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Committee The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Committee The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

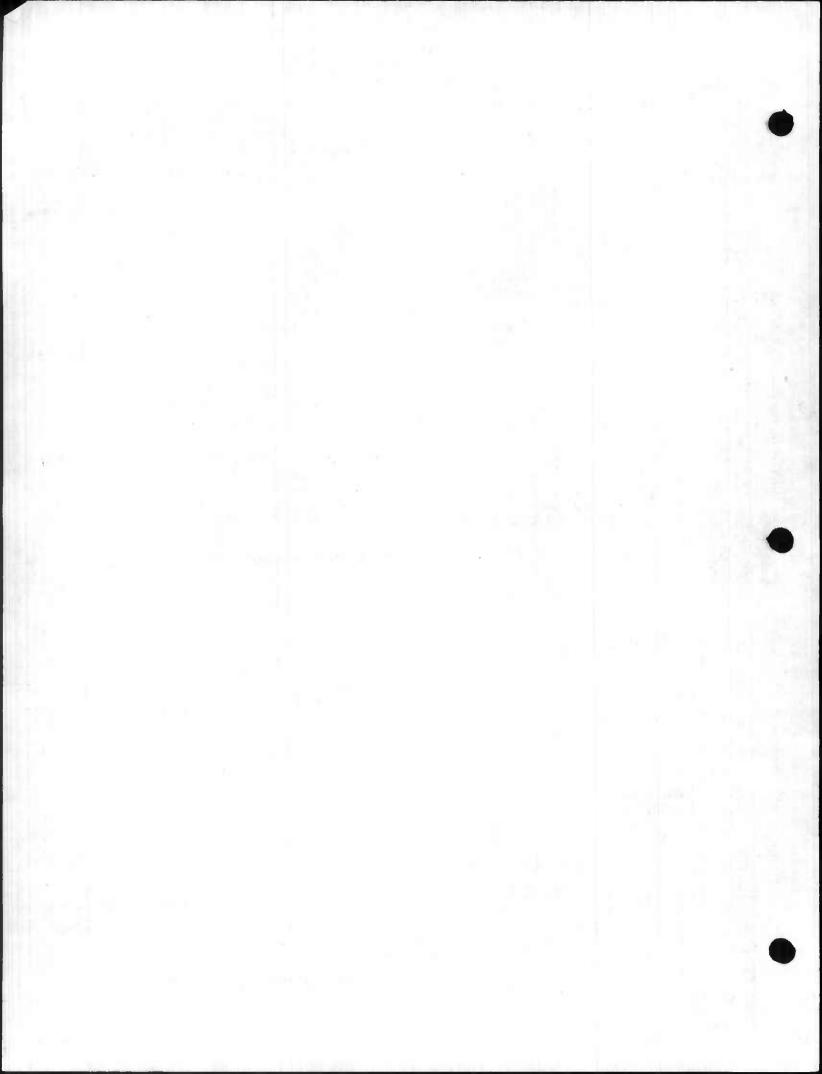
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

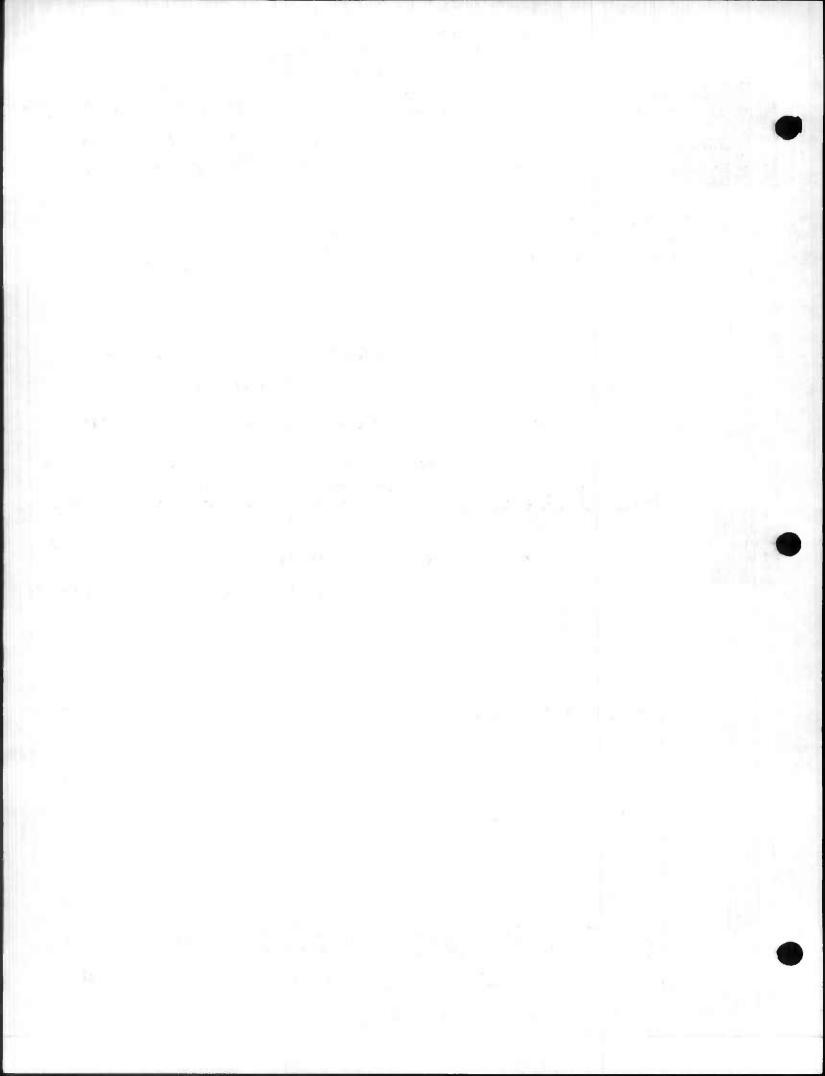
29d. Date signed (Month, Day, Year) MAY 8, 1999

DHMH 16 Rev 6/95



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			1 Donadostia Norsa (Fin	a Bardala I a				icate of			Reg. No.	155	90			
Г	Physici	ian	1. Decedent's Neme (Fin	st, Middle, La	ist)	B	EM	DIE	8	2. Dete of De Month	Dey	Yeer	Time of Death			
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	Francisco I		5. Social Security Number			e (In yrs. last	birthday) If	Under 1 Yeer	2 4 4 1 1	Hrs. 8 Date of Bir	th		(Stete or Foreign			
	Funeral Director		213-01-6122 Usual Residence of Dece		1/	4	Yrs. Me	onths Days	Hours N	March	20,1915	Maryla Maryla	and			
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	r 28	Directo	10e. Street and Number				1	0f. Zip Code			10g. Citizen of V	Whet Country?				
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	deal deal	Funeral	11. Maritel Status		12. Was Decedent Armed Forces?	Ever In U,S.	13. Was			(Specify Yes or No uerto Rican, etc.)		e - American In ck, White, etc.	idlan,			
21215-0020	within 72 hours after death with the Maryland ena. than "naturel", or terms 23a or 28e-f show the Ned cal Examination norther	by	1 ☐ Never Married 2 3 🛱 Widowed 4 ☐ [1 Yes 2X1 I If Yes, Give Year or Dates:			Yes 2 No		geno Aican, etc.)	Specify	te				
2-0	n 72 hours "natural",	Completed	15. [ecedent's E	ducation	1	6a. Decedent'	s Usual Occu	pation during most of	usodeln a	16b. Kind of Bu	usiness/Industry	у			
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21	73 70 1-	Con	Unknown				H	omemak	er		Own	Home				
Maryland	be filed tal Hygid d other evant,	Be (17. Father's Neme (First,)				27.23.5.	Name (First, Middle,	Transfer and the	ne)				
X	Men wid	10	Robert Kir	g					Hav	rriet U	ıknown					
a	and and send		19a. Informant's Name/F			1	9b. Mailing A	ddress (Stree	t end Number o	r Rural Route Numb	er, City or Town,	Stete, Zip Code	9)			
	r tr		Mary Knott	(Nie	ce)				d St., 1	Pale City,	, Virgin	ia 2219	13			
Baitimore,	Se to L		47		Removel from State	20b. Place ceme	of Disposition of the o	n (Neme of ry or other pla	ice)	Dete	20c. Location -	City or Town, S	State			
Ē	Pa nen					Gard	ens of	Faith		5/14/99	Baltimo	re, Mar	ryland			
0			21. Signature of Funerel	Service Lice	nsee		22. Na	me and Addr	ess of Facility							
D	Ped of the second		20a. Method of Disposition 1 & Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 3331 Brehms Lane, Baltimore, Maryland													
	_		23a. Part1. Enter the dis	ease, or com	piications that caused one cause on each li	the deeth. D						App	proximate rval Between			
	Physician		SHOOK, OF HEART IAIR										set and Death			
-	/Medical		Immediate Cause (Final disease or condition		a. recurr b. Sever	ent 1	contic		Lack	ca dine		/	1 d			
	Examiner		resulting in death)		a. / C C C///	Due to (or es	a consequen	ca of):	1 a cong	coyalas	_		- 01			
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00100	ificeta be executed physician and ss tha bunal-transit	edical	that initiated events resulting in death) Last	7	C	Due to (or es	e consequenc	e of):								
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ממ	attanding	lan			U											
;	law requires that the deeth cart as been signed by the attendin t 2 should be detached for usa	Physician/M	Part II. Other significant	conditions	contributing to death b	ut not resulting	g in the under	lying cause gi	ven in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?			
	d by datac		atrial	Fi	brillat	700				1 🗆	Yes 2□ No	3 Probably	Unknown			
2	res ti signe	þ			7.1.	007,										
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	cartificata	Be	25. Was case referred to exeminer?	medicai						Death (Check only	one)					
5	\$ 00	ဥ	1 ☐ Yes 2 No		Hospital:	nt 2 ER/	Outpatient 3	DOA OI	her: 4 Nursin	ng Home 5 ☐ Resi	denca 6 🗆 Oth	er (Specify)				
:	ng Ph fter thi	i.i	27. Menner of Death	Pending	28a. Dete of Inju (Month, De	ry 281 Y Year)	b. Time of Injury	28c. Inju Wo	iry et ork?	28d. Describe	how injury occur	red				
	Attending ir death. ector: After by the fune	catl	2 Accident	investigation					Yes 2 No							
	tar d irect n by	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not b determined	28e. Place of Injuding, etc	ury - At home. c. (Specify)	, farm, street,	factory, offica		28f. Location (City or To	Street and Numb wn, Stete)	er or Rurel Rou	ite Number,			
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 1	Certifying Ph fedicat Exar	ysician: To the best of niner: On the basis of	exeminetion	ige, death occ and/or investi	urred at the ti	ime, date end pi opinion, deeth o	ace, end due to the courred at the time.	cause(s) and ma date and place.	enner as steted.	ceuse(s)			
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			-	Wa	vy,	101	Vi	111	0580	/	Nay	1,19	99			
	10		30. Name and address of Calhrin Wa	person who	completed cause of d	eeth (Item 23	a) (Type, Print	" [[]	11 (al. n.	ven R1. 1 1	Bult man	MOOK	239			
	/		Calhrin Wo	184,1				100	11 0000 100	in piral	tech i work	1 0	()			
	Sta		31. Date filed (Month, Da			ar's Signature	1	1								
	Registr	ar	W/A	Y 12	IUUU P^.	MARKE	14									



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death 22.20P BROOKS Day CELESTINE MAY ENTH 1999 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie North Arundel Hospital 5. Social Sacurity Number 6. Sex If Undar 1 Year 8. Data of Birth Month Day. Year May 14, 1918 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months 80 Days Hours 1 ■ M 2 214-14-3043 Yrs Md. Usual Rasidanca of Decedant 10b. County n/a 10a. Stata 10c. City, Town or Location 10d. Insida City Limits Baltimore 1 Nes 2 No 10g. Citizan of What Country? USA 10a. Street end Number 10f. Zip Coda 21225 211 Cedar Hill Lane 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 25 No if Yas, Giva Yaar or Dates: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11 Marital Status Black, White, atc 1 Nevar Marriad 200 Married **Black** 1 Yas 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Soc. Sec. Dept. Clerk 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charles Howard Celestine Williams 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stefe, Zip Coda) Cornell Milton Brooks 211 Cedar Hill Lane Baltimore, Md. 21225 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from Stata Cedar Hill Cemetery May 15 Brooklyn, Md. 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature Funeral Service Doensey Eme 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause or part line. Approximete Intarval Batween Onsat and Death MYOCARDIAL INFARCTION LESS THAN Immediata Causa (Final ONE HOUR disaasa or condition rasulting in death) Due to (or es a consequence of): CORDNARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury lihat initiated avants rasulting in death) Last Dua to (or es e consequence of): Dua to (or as a consequanca of) 23b. Did tobacco usa contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Md.

Director

Funeral

py

Completed

Funeral

Director

th and Mentel Hygiene. 7 is marked other than "natural", or flems 23s or treumstic event, to Medical Executer mant to a

Pages 1 and 2 should be filt ment of Heelth and Mentel Hy ant; if Item 27 is marked oth jury or other treumstic event

permit. Page Department o Important: If I eny Injury or

with the Meryland or 28a-f show

filed within 72 hours after deeth

Baltimore, Maryland 21215-0020

physician end s the buriel-transit lew requires that the deeth certificate be executed P.O. Box 68760, SES USB signed by the e Division of Vital Records, page 2 certificate Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific. director.

Physician/Medical à Completed Be 0

edical

Examiner funeral Certification: To the Hospital or Atterwithin 24 hours after dee To the Funerel Director completely filled in by th

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASPIRATION PNEUMONIA.

DIABETIES MELLITUS, HYPERTENSION

HRONIC GBSTRUCTIVE LUNG DISEASE

25. Was casa rafarred to madical axaminar? 1 Yas 2 No 27. Manner of Death

29a. Cartifiar

(Check only one)

1 Natural 5 Panding invastigation 2 Accidant 3 Suicida

6 Could not be datermined 4 Homleide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify)

1 Yes 2 No 3 Probably 4 Hunknown

24a. Wes an autopsy

24b. Wara autopsy findings avelleble prior to complation of causa of death?

1 Yas 2 ANO 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona)

Other: 4 Norsing Homa 5 Residence 8 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1 Cartifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) end menner stated. 29d. Data signad (Month, Day, Year)

29c. Licansa numbar 29b. Signatura and titla of certifiar angerajan. M.D

10054288

30. Nema and eddress of person who complated causa of death (Itam 23a) (Type, Print)
RAMASINANTY RANGIARATAY 7445 E FURNACE BRANCH ROAD GLEN BURNIE MD 21060

Registrar

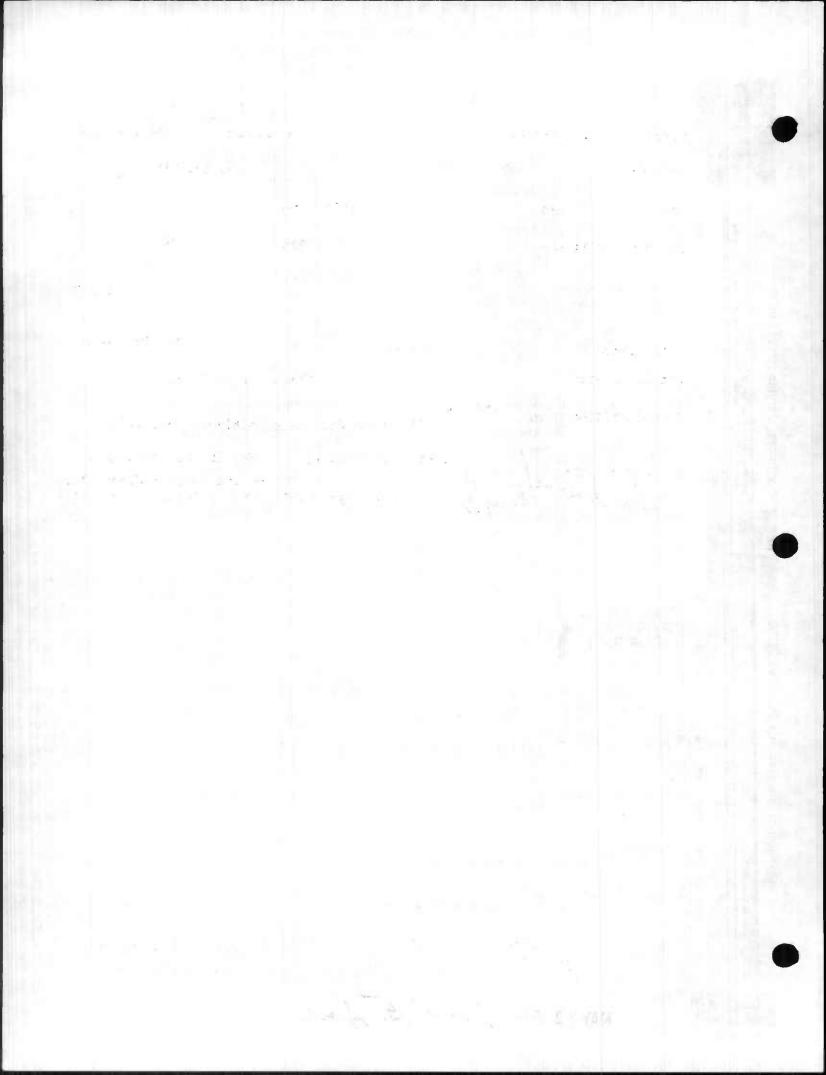
31. Data filed (Month, Day, Year)



Sparks

28c. Injury at Work?

1 Yas 2 2 No



99-2617-510 MARK BLEDSOE Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene UNKNOWN 99-093 Certificate of Death 5500 Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Year Month MAY **Physician** Mark Sheron Bledsoe 1999 8, 0207 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner n/a 2100 block DRUID PARK AND BLOOM STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Days Hours 10M 20 F 143-64-0755 31 Yrs Aug. 12, 1967 Director Usual Residence of Decedent 10c. City, Town or Location Baltimore 10d. Inside City Limits Md. n/a 1XX es 2 □ No Director or Harris 23a or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1942 Ridgehill Avenue 2121 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after TXXYes 2 No 1 Never Married 2 Married Black Baltimore, Maryland 21215-0020 1 ☐ Yes 200 Specify: Specify: by 3 Widowed 4 Divorced Year or Dales: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Telephone Marketing Rep. Tele Spectrum 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental H ant: If Nem 27 is marked off jury or other traumatic even Be Dennis Hayes Carolyn Ann Bledsoe 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Brandon T. Curry 1635 Division Street Baltimore, Md. 21217 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 Cremation 3 Removat from State May 13 Baltimore, Md. King Memorial Park 5 Other (Specify) 21. Signeture of Funeral Service Licens 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. mes 23a. Part Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. physician s the burial Physician/Medical Due to (or as a consequence of): 950 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2□ No

The law requires that page 2 s of Vital or Attanding Physician: this funeral After Division s after death.

Completed Be Certification: To filled in by

25. Was case referred to medical examiner? XIX Yes 2 No

27. Manner of Death 5 Pending investigation 1 Naturei 2 Accident 3 Suicide 4 Homicide

(Check only

6 Could not be

May 8, 1999

28a. Dete of Injury (Month, Dey Year) 28e. Mace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 2:05 AM

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence All Other (Specify) AT SCENE 28c. Injury at Work?

1 Yes 2 No

26. Place of Death (Check only one)

28d. Describe how Injury occurred Subject was shot

281. Location (Street and Number or Rural Route Number, New City or Town, State) 2100 block DRJD Park BALTIMORE, MD 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier nue 29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) MAY 8, 1999

30. Name and address of person who completed gruse of death (Item 23a) (Type, Print)

HEOROPHEN, KING 31. Date filed (Month, Dey, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

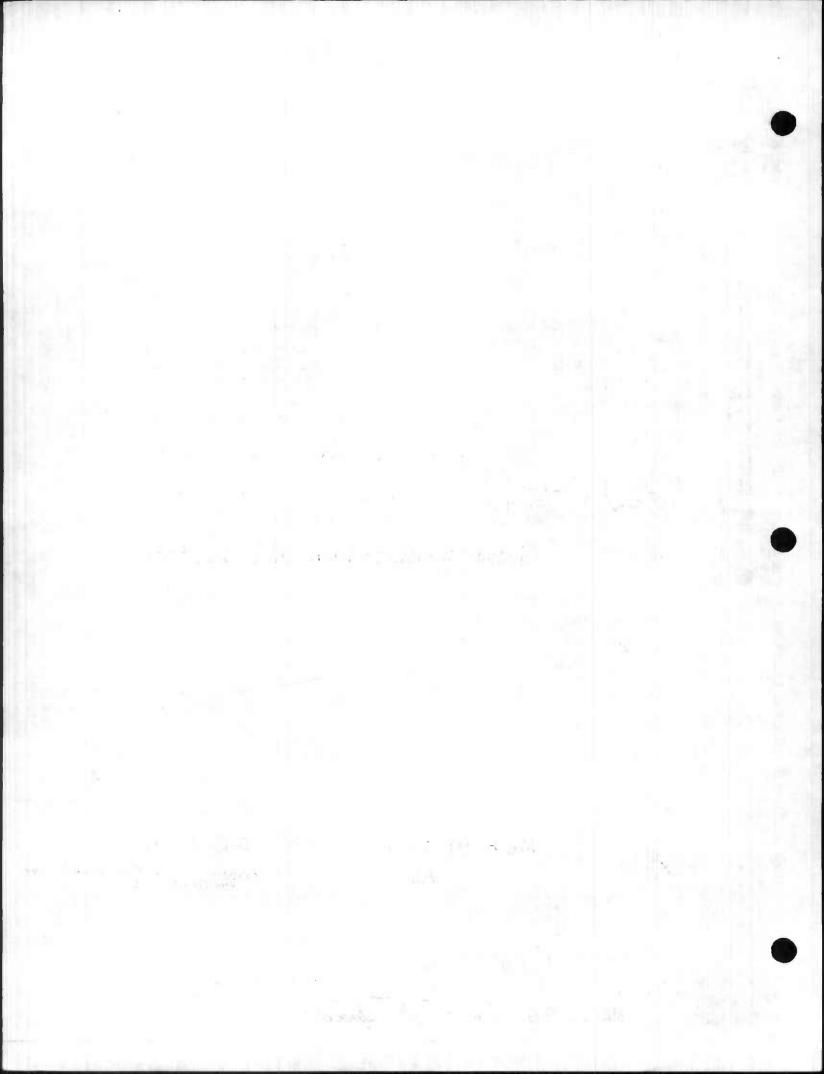
MAY 12

32. Registrar's Signature south

24 hours

within 24 hor To the Fune completely fi

To the Hospital



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 50 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Stephen Robert Boyce MAY 3, 1999 2:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Beechwood House Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 110 M 2□ F Months 17 220-13-7047 Director SEPT. 29. 1981 Washington, Usual Residence of Decedent 10s. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☑ No Elkridge Director Howard 報 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 7734 Washington Blvd., #22D 238 21075 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 21215-0020 8 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student 10 N/A Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Department of Health and Mental Important: If Item 27 is marked or Robert Stephen Boyce Patricia Ellen Mansfield 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert & Patricia Boyce -Parents 7734 Washington Blvd., #22D, Elkridge, Md. altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 5/06/99 1 Durial 2 Cremstion 3 Removel from State Meadowridge Memorial Pk. Elkridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service License Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner) nai mos The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ond Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causs of death? Records, P.O. been signed by should be detacl 1 Yes 2 X No 3 Probably 4 Unknown ρ Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? 1 ☐ Yes 20 No certificate Division of Vitai or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) assi 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 XiNaturat 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 Yes 2 No 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide the Hospital edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIT 8. LEFFL res

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DHMH 16 Rev 6/95

State

Registrar

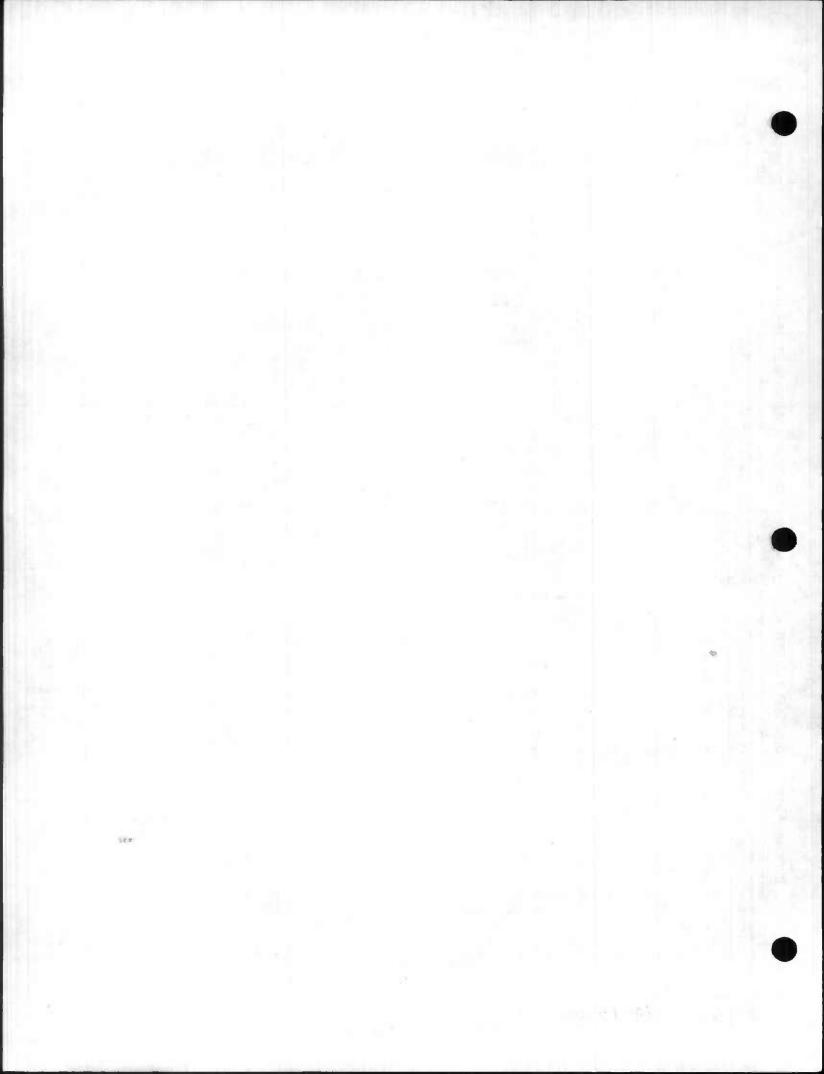
31. Date filled (Month, Day, Year) MAY 1 2 190

1999

ORIGINAL

21042

32. Registrar's Signature



WILLIAM BYNE

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / D

Department of Health and Mental Hygiene	0	0	
Certificate of Death))	

Physician
/Medical
Examiner

Director

Funeral

à

Completed

Be 2

William J. Bavne 4a Facility Neme (If not institution, give street and number)

8, MAY 4b. City, Town, or Location of Death BALTIMORE

3. Time of Death 0440 AM

5594

Funeral

5 Social Security Number 6 Sex 1€M 2□ F 217-76-7198 Usual Residence of Decedent 10a State 10b. County

UNION MEMORIAL HOSPITAL E.R.

If Under 1 Year 7. Age (In yrs. last birthday) Months Days

Hours Min. 8. Deta of Birth (Month, Day, Year) March 6,1959

2. Date of Death

 Birthplace (Stata or Foreign Country) MaryTand

Director

than "netural", or items 23s or the Medical Examiner must be r

permit. Pages 1 and 2 ahould be filed within 72 hours after a Department of Health and Mental Hygiene. Important if them 27 is marked other than "natural"——any injury or other traumatic average.

Physician /Medical

Examiner

attending physician and for use as the burlel-transit certificate be axecuted

3

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After

To the Hospital or Attending Pt within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funera

68760

Box (

P.O.

Records,

Division of Vital

Examine

Physician/Medical

by

Completed

8

To

Certification:

Medical

the Maryland r 28a-f show

Maryland N/A 10c. City, Town or Location Baltimore

Yrs.

10d. Inside City Limits 1 Yes 2 No

USA

Day 1999

N/A

4c. County of Death

10e. Street and Number

3802 Elm Avenue 11. Merital Status 1 Never Married 20 Merried

1. Decedent's Name (First, Middle, Last)

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yas, Give Year or Dates:

College (1-4or 5+)

40

21211 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2) (I)No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

Printing Company

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Folder Operator

16b Kind of Business/Industry

10g. Citizen of What Country?

Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)

George Bayne

Beverly Woods

18. Mother's Name (First, Middle, Maiden Sumame)

19a. Informent's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3802 Elm Avenue, Baltimore, Maryland

Cheryl J. Bayne Wife 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) Date Balto. Washington Crematory 5/11

10f. Zip Code

20c. Location - City or Town, State Laurel, Maryland

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetjon 5 ☐ Other (Specify)

21. Signatury of Funerel Service Licensee

22. Name end Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Pert1. Enfar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each lina.

Arteriosclerotic Cardiovascular Disease

Approximate Intarvel Betw Onset end Death

Immediata Causa (Finel disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or es a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

XIX Yes 2 □ No

27. Mannar of Death

XIXNatural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 No

INSPECTION

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case refarred to medical examiner? 26. Place of Deeth (Check only one)

Hospital: 1 Inpatient 20 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signetura and titla of certifier

6 Could not be determined

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) MAY 8, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

MD 30. Name and address of person who completed cause of south (item 23a) (Type, Print)

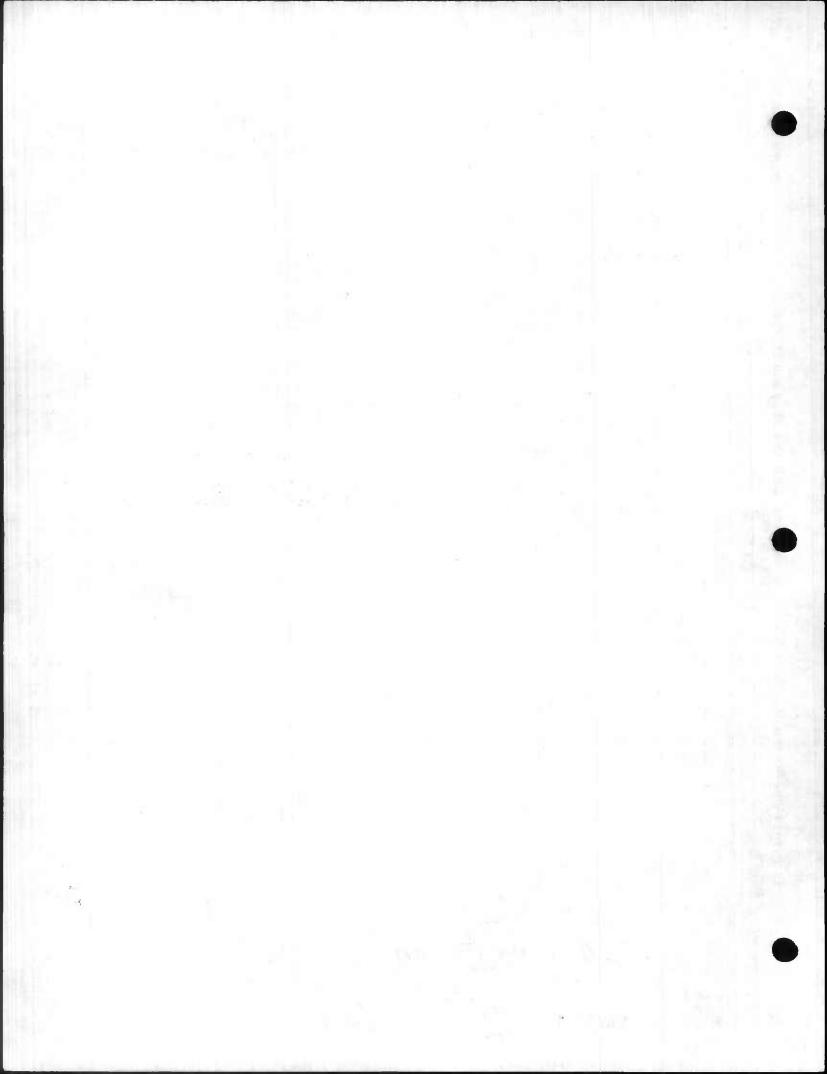
Stephen Radentz, M.D. 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

MAY 1 2 1999

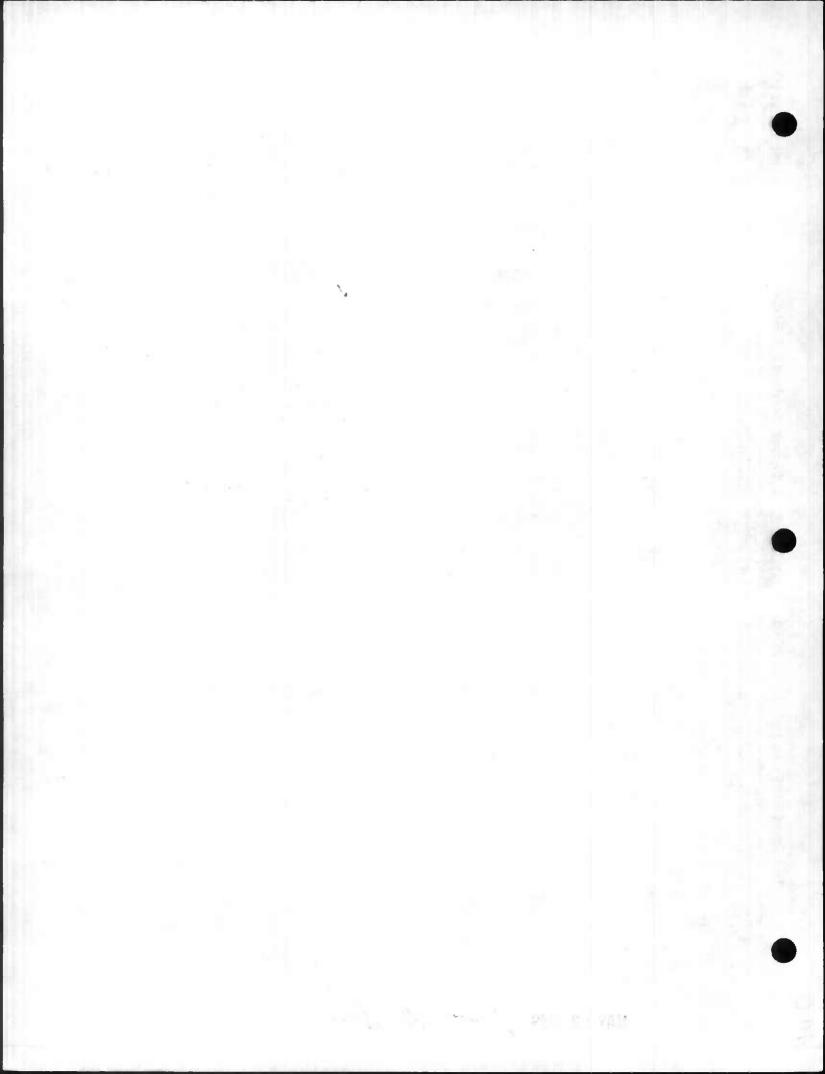
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 99 | 5595

			Ce	ertificate of	Death		R	leg. No.		000				
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Physician /Medical	VICTORIA V. E	ONKOWSKI				MAY		999	9:18	AM				
Examiner	4a Facility Neme (If not institution, g	ive street and number)		4b. City, To	wn, or Loca	tion of Death	4c. County	of Death						
	HOPKINS BAYV				BA	LTIMO	RE	N/A						
Funeral Director	219-12-5521	Sex 7. Age (In yrs. last birthday 89 Yrs.	Months Day	r If Under	Min.	Deta of Birth (Month, Day 2/28	7 / 1 0	Cou	place (State on ntry) SISSI				
2 K-	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or L	ocation					T	10d. Inside C	ity Limits			
vith the Mary to or 28a-f shu be notified a	MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code								1 XYes 2 No € What Country?					
					21213			U.S	J.S.A.					
ZIZID-UUZU d within 72 hours after death v given. r than "natural", or hams 23. ha Medical Examinar must	3 Nowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No lif Yes, Give Year or Detes:	1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Ye			gin? (Speci i, Puerto Ri	ly Yes or No- can, etc.)	14. Race - American Ind Black, White, etc. Specify: WHITE						
ed within 72 ho or than 'natura', the Medical.	15. Decedent's (Specify only highest of	Education rade completed)	16a. Dec	edent's Usuel Occi	pation e during mos	t of working		16b. Kind of Bu	siness/In	dustry				
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A Sah	19e. Informant's Name/Ralationship		100	ling Address (Street						Code)				
- 55% 5	MR. LAWRENCE	BONKOWSKI	812.	3 WOODH	AVEN I					212	37			
altimore mil. Pages 1 portanti if ten y injury or oth	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spec		cemetery, cre	emetory or other pi		5/10/	Deta / 99 I	20c. Location -						
Balt permit Depart Import any inj any inj	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility KACZOROWSKI FUNERAL HOME P.A.													
	23a. Pert1. Enter the disease, or co shock, or heart teilure. List on								, MD	Approximat	le			
Physician /Medical Examiner	Immediate Cause (Finel disease or condition	SRG							 	Onset and	Death			
	resulting in death)	Du	e to (or as e conse	equence of):					1					
08760, cate be assected physician and is the burial-transit official Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury c.													
E 04 5	resulting in death) Last	C. Du	e to (or es e conse	equence of):										
	Part II. Other significant conditions	contributing to death but r	not resulting in the	undarhina cauca c	iven in Part I		23h Did to	obacco use cor	atelbuda t	o the cause	of death?			
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requir been s should			VI-				24a. Was a perfor	an autopsy med?	an Ct	/era eutopsy vailable prior of completion of death?	to			
vital recovicion: The law certificate has b rector, page 2 s							1 D Y	as 20 No		□Yes 2	Alla			
yaiclan: The li yaiclan: The li director, page To Be Corn	25. Was casa referred to medical				26 Place	of Dooth /	Check only or			□ 105 <i>a</i> €	140			
Physician: This certifical ral director, pr.: To Be C	examiner?	Hospital:	2 RER/Outpatie	ent 3DDOA	thor			ence 6 □Oth	or /Snaci	i6.1				
0 5 5 5 0	27. Manner of Death 1. Natural 5 Pending 2 Accident investigeti	28a. Date of Injury (Month, Dey Y		of 28c. Inj		28		ow injury occurr		'97				
DIVISION C be or Attending P is after deeth. el Director: After t led in by the funeri Certification:	3 Suicide 6 Could not determine		- At home, term, s Specify)	treet, tectory, office	9	28	Location (S City or Tow	itreet and Numb n, State)	er or Aur	al Route Num	nber,			
DIVISION OF To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one) 1 Certifying F	hysician: To the best of miner: On the basis of examiner stete	aminetion end/or in	th occurred at tha nvestigation, in my	tima, date en opinion, dea	d plece, enth occurred	d due to the c et the time, c	ause(s) and me late end place,	nner as a	stated. to the cause(s	5)			
To the within To the complex	29b. Signeture end title of certifier	1	rel		se number	- 7	2	29d. Date signed	(Month,	Day, Year)	36			
	30. Nama and addrass of person who	-	0		s ren	2 4	II.	BME	(^	S 2	2122			
State	31. Date tiled (Month, Day, Year)	32. Registrar's		, , ,	101 -00			Conto		-, .				
Registrar	MAY 12 1	999 \$, en	a B.	Spark	2									

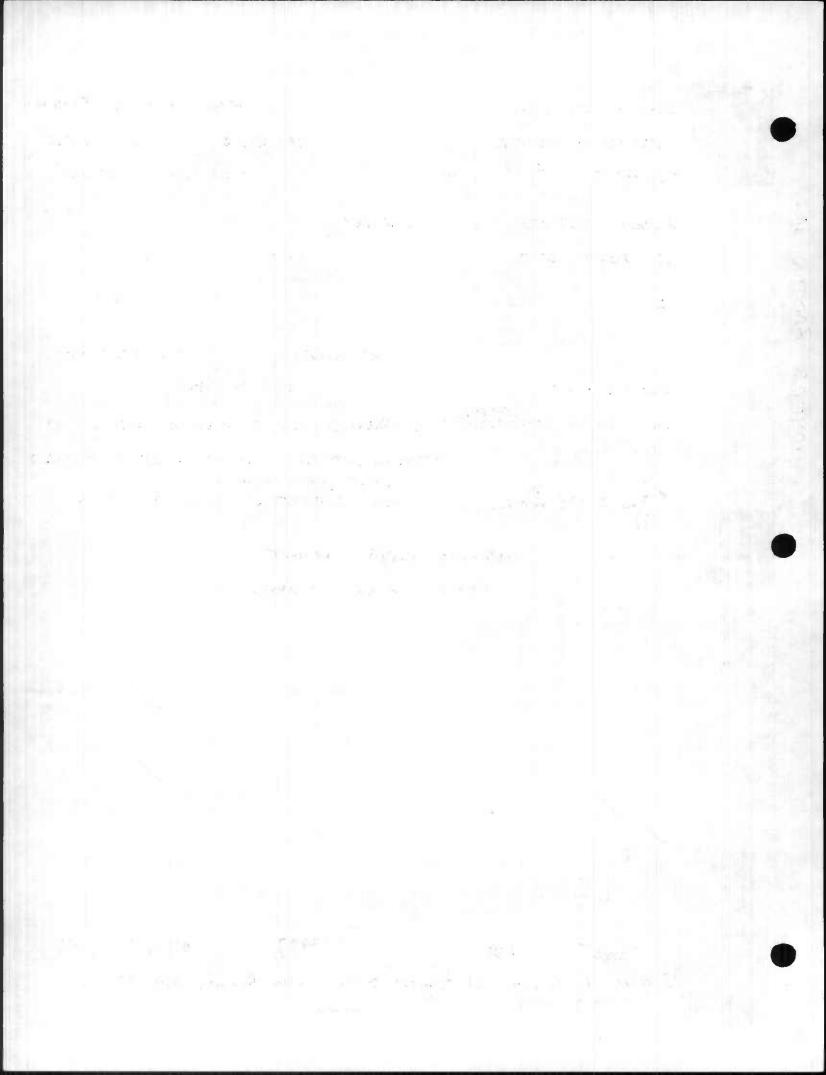
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			Name (First, Middle, L	ast)				RINDREN	2. Data of De		Walte	3. Time of Death			
	Physician /Medical	MARIDA	P. BARTON	, SR.		Month	Day	999	8:35Am						
	Examiner	4o Conitity No	ama (If not institution, g	ive street and number)				4b. City, Town, or	Location of Deat	h 4c. Cou	inty of Death				
		NORTH	ARUNDEL H	OSPITAL				GLEN BU	JRNIE		ANNE	ARUNDEL			
F	Funeral	5. Social Seci	urity Number 6.	Sex 7. Ag	e (In yrs.	lest birthday)	If Under 1 Y Months D	aar If Undar 24 Hrs ays Hours Min		th y, Year)	9. Birth	place (Stete or Foreign intry)			
C	Director	215-07-7252 1M M 2 F 91 Yrs. MARCH 4,1908 MA. Usual Residence of Decedent													
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Maryl	dah or	MADVI	ND DATES				1 ☐ Yes 2X No								
the	or 28a-ta	MARYLA 10e. Street at		MORE	L	DAL.	TIMORE 10f. Zip Co	de		10g. Citizen	of What Cou	intry?			
with	38 0			II	S.A.										
death	r items 234	11. Marital St	FAIRVIEW A	12. Was Decedant		,S. 13.	Was Decedent	21227 of Hispanic Origin? (S Cuban, Mexican, Pue	Specify Yas or No		Race - Amer				
aftar	and UT		Married 2 Married	Armed Forces?					rto Hican, atc.)		Black, White	, etc.			
3-0020	by Every		wed 4 Divorced	If Yes, Give Year or Dates:			1∟ Yes 2Lo	No Specify:		Spe	ecity: WH	ITE			
within 72 hours after death with the Maryland	ital hygiena. d other than "natural", or items 23s or 28s-f show event, the Medical Examinet result or notified at Be Completed by Funeral Director		15. Decedent's E (Specify only highest g			(Give	dent's Usual O	one during most of wo	orking	16b. Kind o	f Business/I	ndustry			
ithin 6	an and	Eiementery	/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use n	etired)							
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D od	even de out		lame (First, Middla, Las	·			ime (First, Middle		neme)						
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_ (1)	E ~ 5		nt's Name/Relationship					treet end Number or F							
Tand -	item 27 other tr	20a. Method	CE PAULINE of Disposition	DAKTON (DAU			WOOD H	OME CIRCLE	Date		MARYLA on - City or T				
5 % C	5 = 5	1 Buria	al 2 Cremation 3		C	emetery, crei	metory or othe	r plece)	5/7/99						
<u>ا</u> يو ا	Department Important: If any injury o	4 Donation 5 Other (Specify) LOUDON PARK CEMETERY 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility								BAL I	LMORE,	MARYLAND			
2 E S	any		400	OME, INC.	•										
	_		inter the disease, or con in heart tailure. List ont	JE - BAL		, MARY	LAND 2122 Approximate								
· Exa	Medical the burial-transit the burial-transit the burial-transit aminer and Examiner	Immediata C disease or co resulting in d Sequentially if any, leading	ondition eath)	a. CONUPS	Due to (o	r as a consec	ENY	PAILURE							
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ficata	s the	resulting in de			Due to (o	r as a conseq	quence of):				- 1				
L cartif	attending p for use as			l d											
death	d for	Part II Other	algnificant conditions	contributing to dooth b	ut not rec	ulting in the u	andodulna cour	o civen in Red I	23h Did	tobacco una	contribute	to the cause of death?			
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ne law requires that the	should should						3			an autopsy ormed?	a	Vere autopsy findings vailable prior to ompletion of cause f death?			
ع ع	age Po								10	Yes 200N	0 1	☐ Yes 2☐ No			
	tor, p	25. Was case	referred to medical					26. Placa of De	eath (Check only	one)					
	is certificate has director, page 2	1 ☐ Yes	20 No	Hospital:	ant 2	ER/Outpatier	nt 3 DOA	Other:	Homa 5 ☐ Rasi		Othar (Spec	sity)			
g Phys	neral di			28a. Date of Inju (Month, De	ry v Year)	28b. Time o	f 28c.	Injury at Work?	28d. Describe	how Injury oc	curred				
2 4		O Assis	lent investigation	on		,,	М	1 ☐ Yes 2 ☐ No							
5 5 5	or: At he fu	2 Accid	da 6 ☐ Could not	28e. Place of Inj	ury - At ho c. (Specif	ome, farm, str y)	reet, factory, of			umber or Ru	28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
or Attending	Mector: Afin by the fu	3 Sulci	lcide determine									rel Route Number,			
Hospital or Atten	Funers birector: After the funers they filled in by the funers lical Certification:	3 Sulci 4 Hom	1 Certifying P	hysician: To the best	examina	wledge, death	h occurred at the	ne time, date and place	ea, and due to the curred et the time,	cause(s) and date and pla	d manner as	stated.			
the Hospital or Attending	inn 24 nous and dean. The Funeral Director: Af Ampletaly filled in by the fu Medical Certification	29a. Certifier (Check or one)	Certifying P	hysician: To the best	examina	wledge, death tion and/or in	vestigation, in	ne time, date and place my opinion, death occ	ea, and due to the curred et the time,	date and pla	ce, and due	stated. to the cause(s)			
To the Hospital or Attendant	pletaly fill edical	29a. Certifier (Check or one)	1 Certifying P	hysician: To the best	examina	wledge, death	vestigation, in	ne time, date and place	ea, and due to the curred et the time,	cause(s) and date and pla	ce, and due	stated. to the cause(s)			

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dorip Barringtan

4a Facility Name (If not institution, give street and number) 1042 May 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ch NOTH Prunkel Burne If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days 10 M 20 F Months 032-20-9654 MASSACHUSETTS Director MARCH 9,1919 Usual Residence of Deceden the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL **PASADENA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8320 FAIRWOOD DRIVE 21122 U.S.A. Funeral death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Giva Yaar or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Ricen, etc.) Biack, White, etc. 1 ☐ Never Marriad 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiena. Important: if Item 27 is marked other than * any injury or other teaumatic event, in the any injury or other teaumatic event. Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) HOSPITAL SECRETARY !@TH GRADE 4 YRS 18. Mother's Name (First, Middle, Maidan Surname) 17. Fethar's Name (First, Middle, Last) ALICE E. SULLIVAN FRANCIS W. GLANCY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 8320 FAIRWOOD DRIVE - PASADENA, MARYLAND 21122 CHARLES E. BARRINGTON (SON) 20b. Piace of Disposition (Name of cemetery, crematory or othar placa) Date 20c. Location - City or Town, State 20a. Method of Disposition 15 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/14/99 LOUDON PARK CEMETERY BALTIMORE, MARYLAND 22. Name and Address of Facility HOME, INC. 21. Signature of Funeral Service Licensee any Ir marriage 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Momao 23a. Part I. Butar the disease, or complications that ceused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shoot, of heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Deeth Physician Possible Convery attack Variest Hours /Medical Immediate Cause (Final disease or condition resulting in daath) Examiner Examiner Caren physician and the burial-trans Sequantially iist conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last Physician/Medicai Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa raferrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospitai: 1 Hopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funaral 27. Mannay of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 D Maturai or Attendination after death. investigation 2 Accident 6 Could not be datermined 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 I Homicide 24 hours a 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Within 2 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number to Ash renday 004832

DHMH 16 Rev 6/95

State Registrar

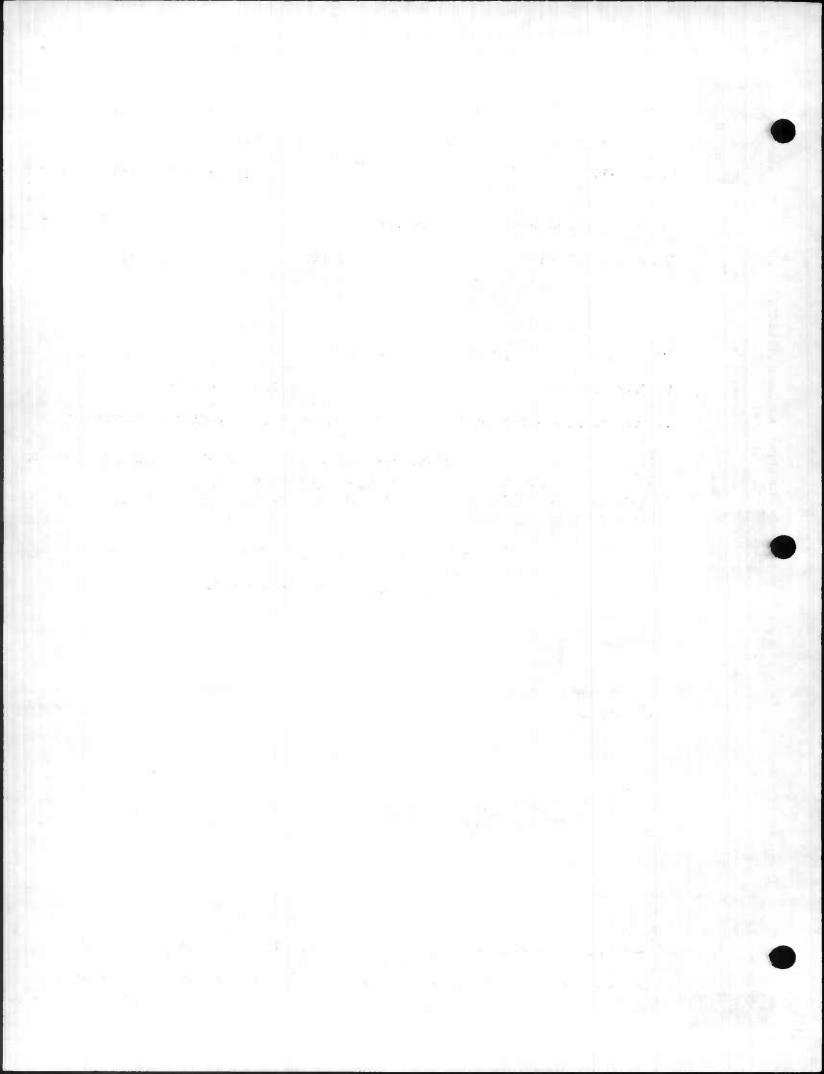
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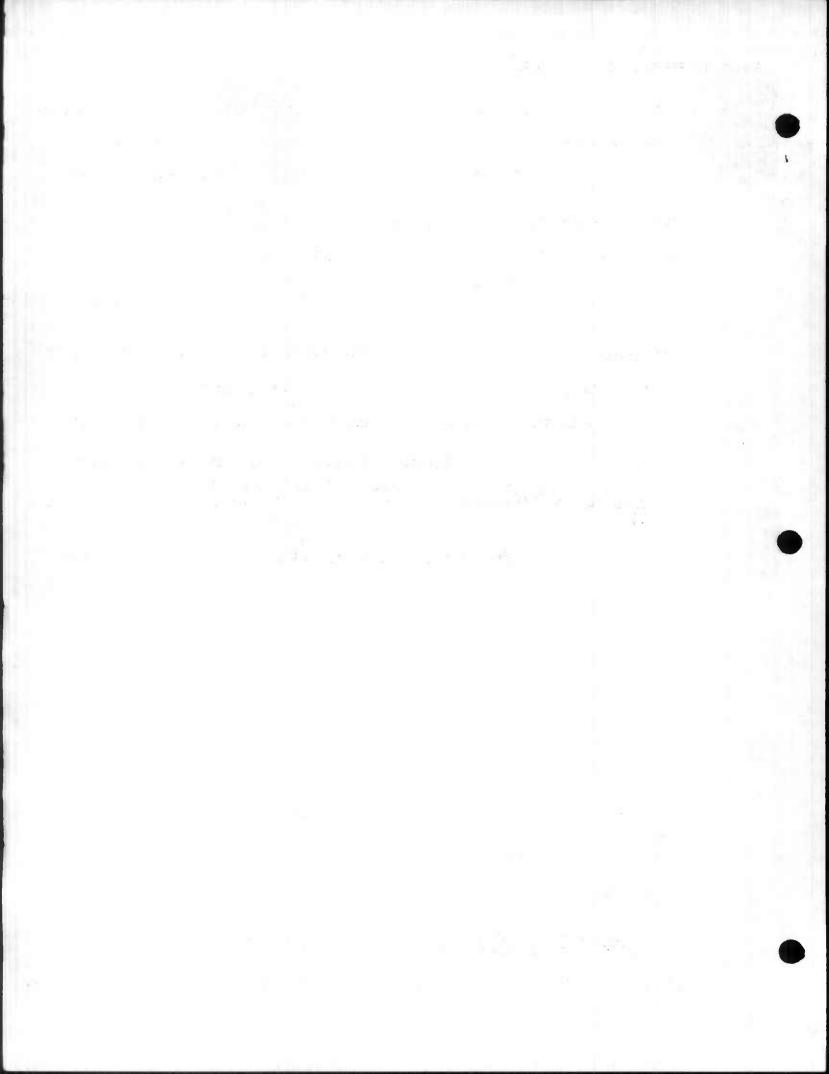
SABUNDAGO 32. Registrar's Signature'

30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

Frederich Road, Contonanilo



MENEU	#24a	PER DOC. 5-14-99		J.A.	or maryia		rtificate			ATTOL IV	lental Hy	Reg. No.	9)	559
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/Med		PAULINE			REIS						MAY	4,	199		5:15
Exami	iner	4e. Fecility Nama (If not institu	ition, give	street and nu	ımbar)			4	4b. City, To	wn, or L	ocation of Dea	ith 4c.	County	of Death	
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2 should 2 and Man 1s marke raumatic		JOHANN SPORL							E	EMIL	IE HAUI	ELEIN			
		19a. Informant's Name/Ralation	onship (Ty	rpe, Print)		19b. Maili	ng Addrass	(Streat	and Numbe	or or Run	al Routa Num	ber, City o	r Town,	Stata, Zij	p Code)
		EMILIE M. BA	UERE	IS (DA	UGHTER	231	1 POP	LAR	DRIVE	I - I	WOODLAV	VN, M	ARYI	LAND	21207
		20e. Mathod of Disposition 1 🖾 Burlal 2 ☐ Cramatic		No 1 do		Place of Dispo cematary, crai	osition (Nam matory or ot	ne of thar plac	ce)	1	Data	20c. Lo	cation -	City or To	own, Stata
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month May Edith Covaher 5:00 AM 10 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Johns Hopkins Geriatric Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year, March 4,1914 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Days Hours 10 M 2 N F Months 215-22-4734 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Timonium Maryland Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21093 U.S.A. 106 Washington Street 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Own Residence Homemaker 12 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Burrows Francis Lawrence Cardwell Mary 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Name/Relationship (Type, Print) 106 Washington St. Timonium, Md. 21093 Ms. J. Kathleen Covahey Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burlat 2 Cremation 3 Removal from State Dulaney Valley Mem. Gdrn. 5/13/99 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell Wiedefeld FUNERAL HOME INC. 21 Signature of Funeral Service Licensee 6500 YORK Rd. 21212 23a. Part1. Enter the disaase, or complications that ceuse in death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset and Death Immediate Cause (Finel Aspiration Pneumonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dehydration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Depression 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, it a Wed cal Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, it a Wed call Exempted 2009.

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29a. Certifier

(Check only one)

29b. Signature and title of certifier

Jimmy Edmond

Jummy Elmond MO

Baltimore, Maryland 21215-0020

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death

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.

Funeral Director: Af To the Hosp within 24 ho To the Fune completely fi

> State Registrar

31. Date filed (Month, Dey, Year)

30. Name and discress of person who completed cause of deeth (Item 23a) (Type, Print)

MO

32. Registrer's Signature Sports

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

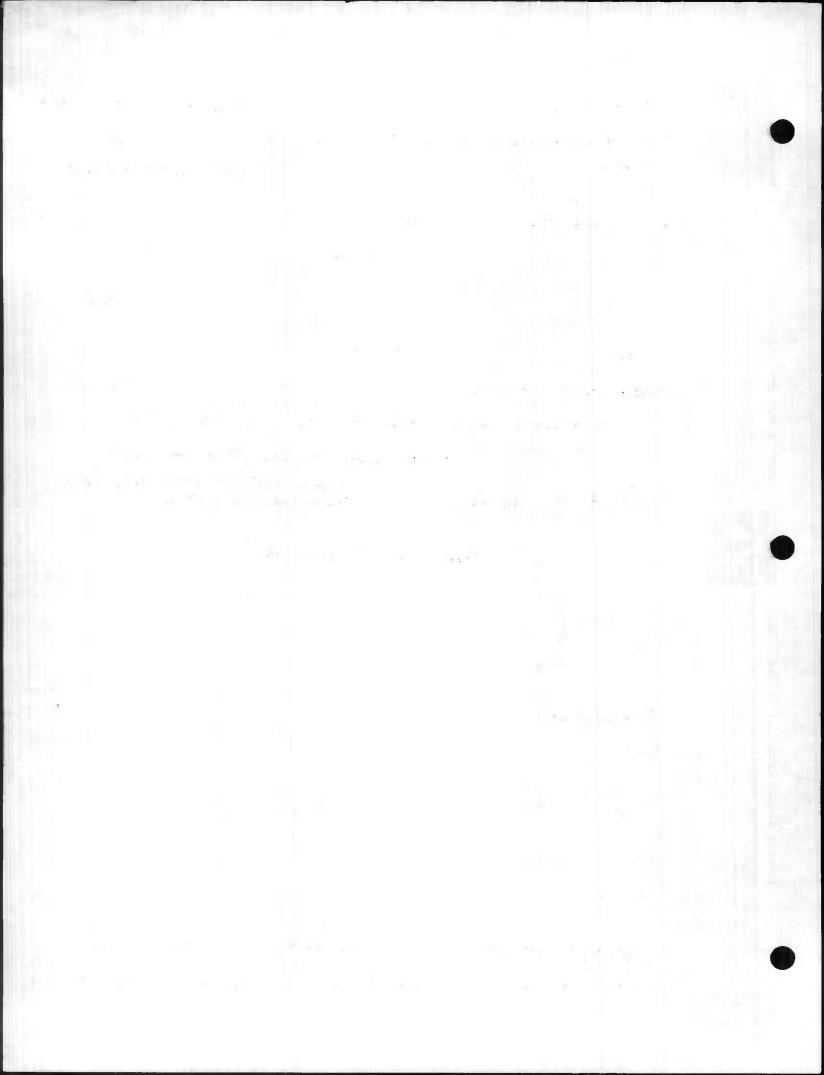
29c. License number

D005314

5505 Hopkins Bayview Circle, Baltimore Maryland

29d. Date signed (Month, Day, Year)

May 10, 1999

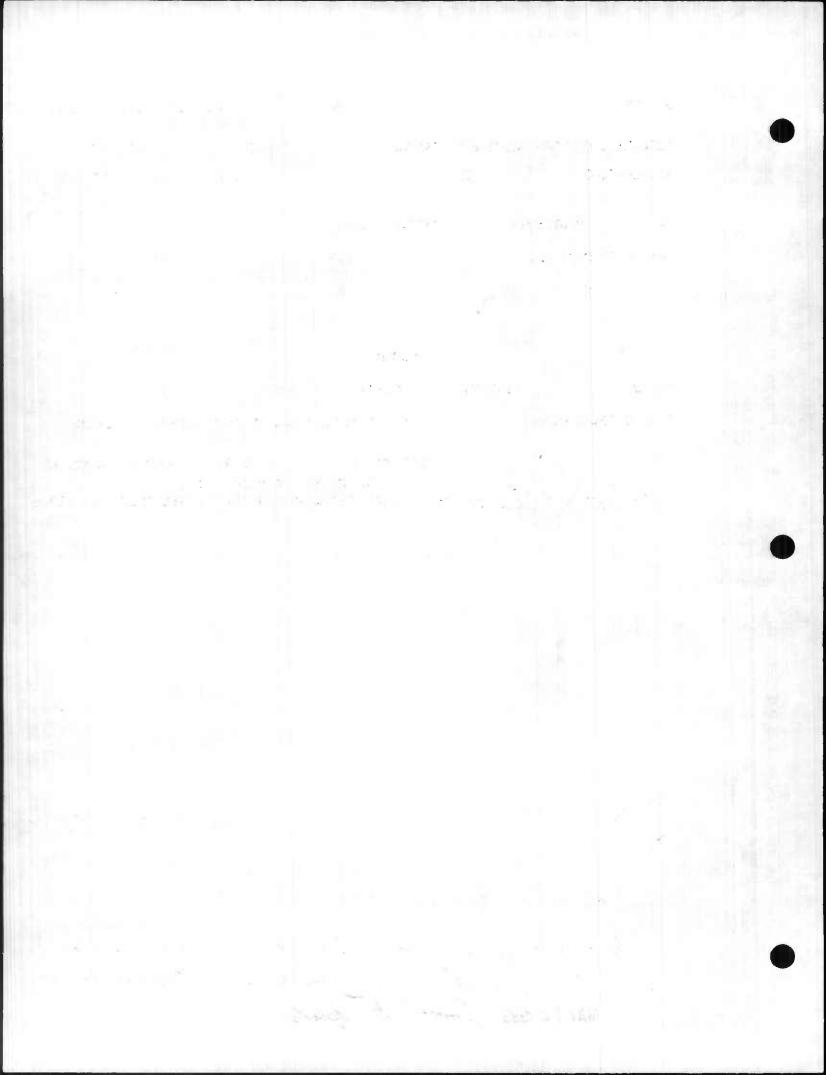


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Robert Conen May 11,1999 e gaspun



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day 10:57am Wilbert Horace 4b. City, Town, or Location of Deeth 99 07, 4e Fecility Name (If not institution, giva street end number) 4c. County of Death 2202 Christian Street Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) 12-05-35 6. Sex Birthplace (State or Foreign Country) 1₽M 2□F Months Deys Hours 63 Yrs 217-32-1031 MD Usual Rasidance of Decedent 10e Stete 10b Count 10c. City. Town or Location 10d. Inside City Limits MD NA Baltimore 1X Yes 2 □ No 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? USA 2220 Christian Street 21223 13. Was Decedent of Hispenic Origin? (Specity Yes or No-lf Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Wes Decedent Evar in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2√∑ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3€ Widowed 4 Divorced Yaar or Detas: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa retirad) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) unemployed Disabled 12th grade 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fathar's Nema (First, Middle, Last) Renees Gibson Day James 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2 1 2 2 3 19a. Informant's Neme/Relationship (Type, Print) 2202 Christian Street Baltimore, Maryland Jackie R. Day 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) 20s. Method of Disposition 20c. Location - City or Town, Stete ¥ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-15-99 Kings Mem. Pk. Cem. Randallstown, MD Sponation 5 Other (Specify) 21. Signal of Funeral Service Licensee 22. Name and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Pert 1. Enter the disease, or complications that bedsed the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failura. List only one causa on each lina. Approximata Intervel Between Onsat and Death immediete Cause (Final CARCINOMA OF PHE LUNG WITH HETHSTASES 4-MONTHS disaase or condition resulting in deeth) Due to (or es a consequenca of) Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Diseesa or Injury thet initiated evants resulting in deeth) Lest Dua to (or es a conseguença of): Due to (or es a consequança of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Ves 2 No 3 Probably 4 POnknown 24b. Ware eutopsy findings evalleble prior to completion of causa of daath? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes case raferred to medical 26. Piace of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menper of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding invastigetion 1 Natural 1 Yas 2 No 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, ferm, straet, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicida

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Baltimore, Maryland 21215-0020

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State Registrar

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29c. License number DO6933 29d. Data signed (Month, Day, Year) MAY 10 - 1999

and eddress of person who completed cause of deeth (item 23a) (Type, Print)

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2 Madical Examinar: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, data and place, and dua to the causa(s) end menner stated.

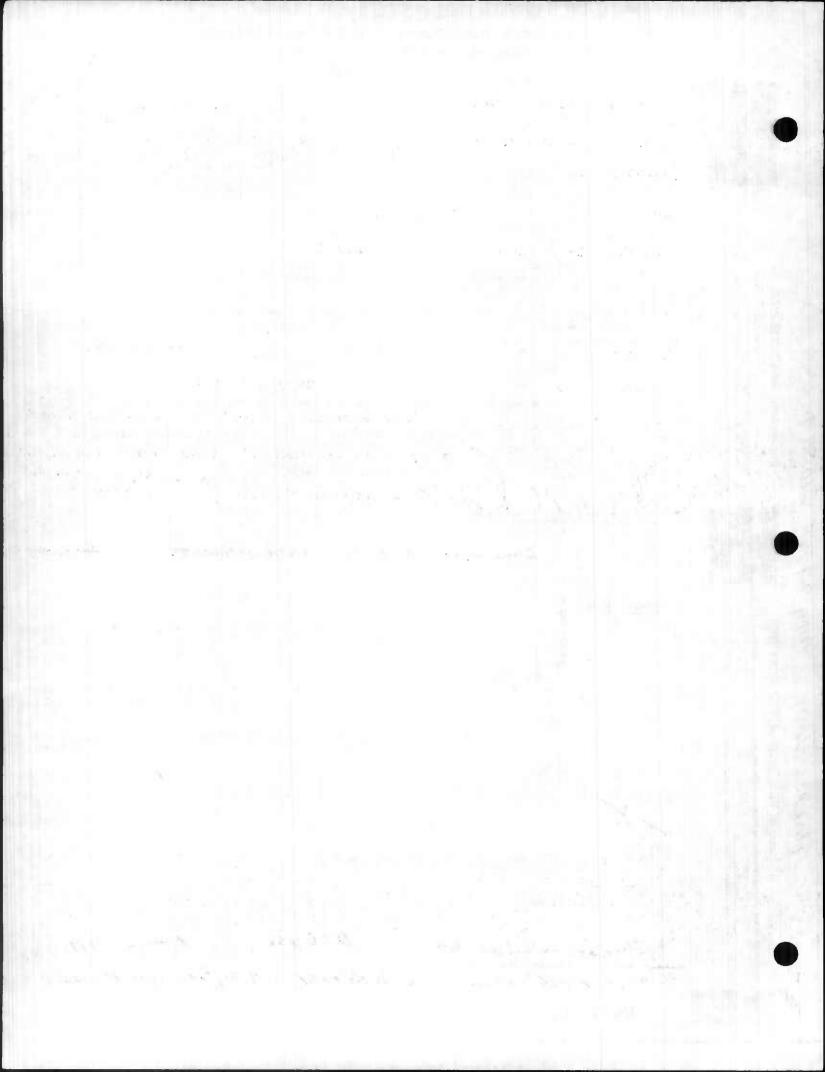
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DHMH 16 Rav 6/95

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Vear Physician Mercedes Dougherty Rose Mo.y 4b. City, Town, or Location of Death ninth 1999 2:05 Am /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Oak Crest Care Center Parkville Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months Deys 1□ M 2XF 214-34-3522 August 14 1921 Pennsylvania Director Usual Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Parkville Directo r than "natural", or learns 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. #2312 21234 United States Dougherty, Kose 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education Department of Health and Mental Hypli Important: If Item 27 is marked other any injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 2 should be f and Mental h Charles Joseph Terry Bernadette Dippel 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James Robert Dougherty / Husband 8800 Walther Blvd. #2312 Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 5-12-99 New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Fecilit Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Stage I Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Dehydration, Epilepsy, HTN, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1□ Yes 2XNo 1 ☐ Yes 2 ☐ No this certificata To the Hospital or Attanding Physiolan: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Matural 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie lumm D34941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar MAY 1 3 1999

SUSAN G.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

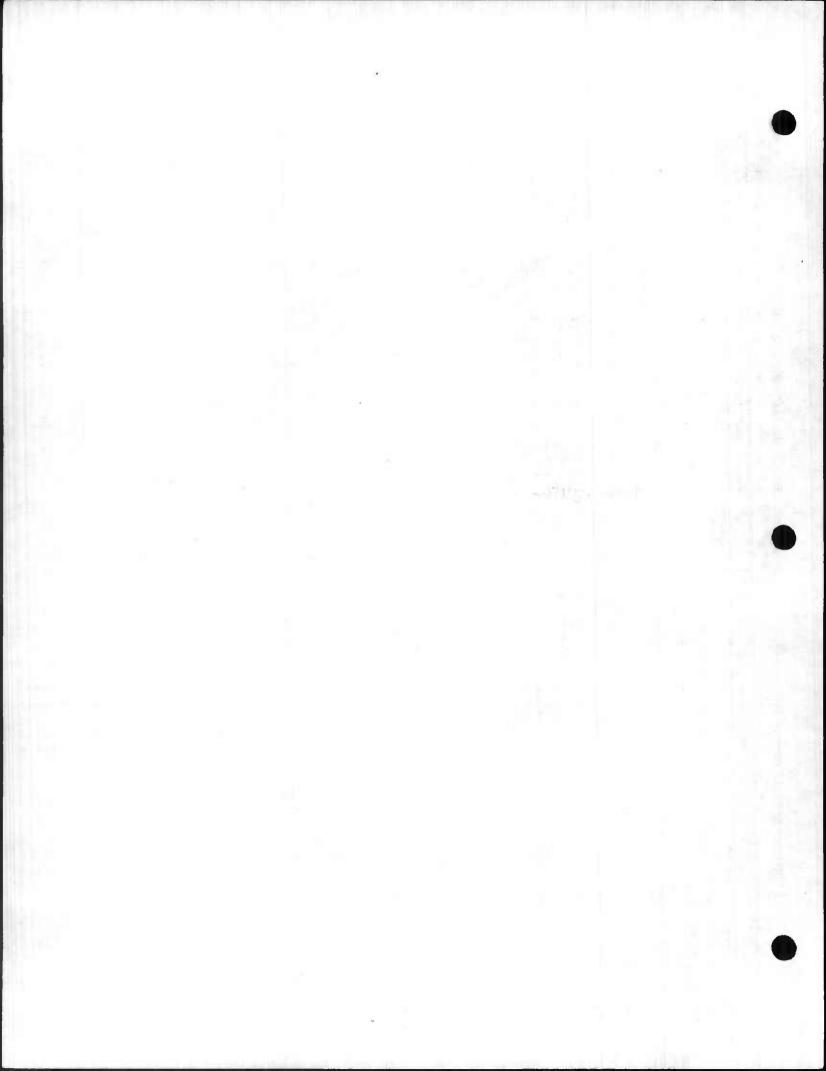
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B. Sports

8800

Walther BlvD

Parkville, Md 21234



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 255 AM Sudie Eaddy 4b. City. Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) General Bul tomore Makyland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 13, 1913 Birthplece (State or Foreign Country) SC (In yrs. last birthday) 250-62-2578 1□ M 257 Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore 1 No Xes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 943 Argonne Drive USA 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 ☐ Married Black 1 ☐ Yes 2XMio Specify: 3√Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Family Housewife 8th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Sudie Hammette Junior Gamble 19b. Malling Address (Street and Number or Rurel Route Number, City or Jown, State, Zip Code) 4142 The Alameda Baltimore, Md. 21218 19a. Informant's Name/Relationship (Type, Print) Mark Eaddy 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩XBurial 2 Cremation 3 Regrovel from Stete May 15 Baltimore, Md. Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Em ications that carried the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): thet initieted events resulting in death) Last Due to (or as a consequence of): Part Ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? ailure 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident

ed by the attending physician and detached for use as the bunal-transit Box 68760. 8 Records, P.O. signed by t peen Division of Vital funeral Aftert death. To the Hospital or Attendiwithin 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Examiner Physician/Medical þ Completed Be To Certification:

Physician /Medical

Examiner

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Director

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Hygiene. other than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at

Important: If item 27 is marked other any injury or other traumatic event, it since.

Baltimore, Maryland 21215-0020

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Pages 1

Physician /Medical

Examiner

25. Was cese referred to medicel examiner? 1 Yes 2 No 27. Manner of Death

3 ☐ Suicide

investigation 6 Could not be determined 4 Homiclde

MAY 12

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

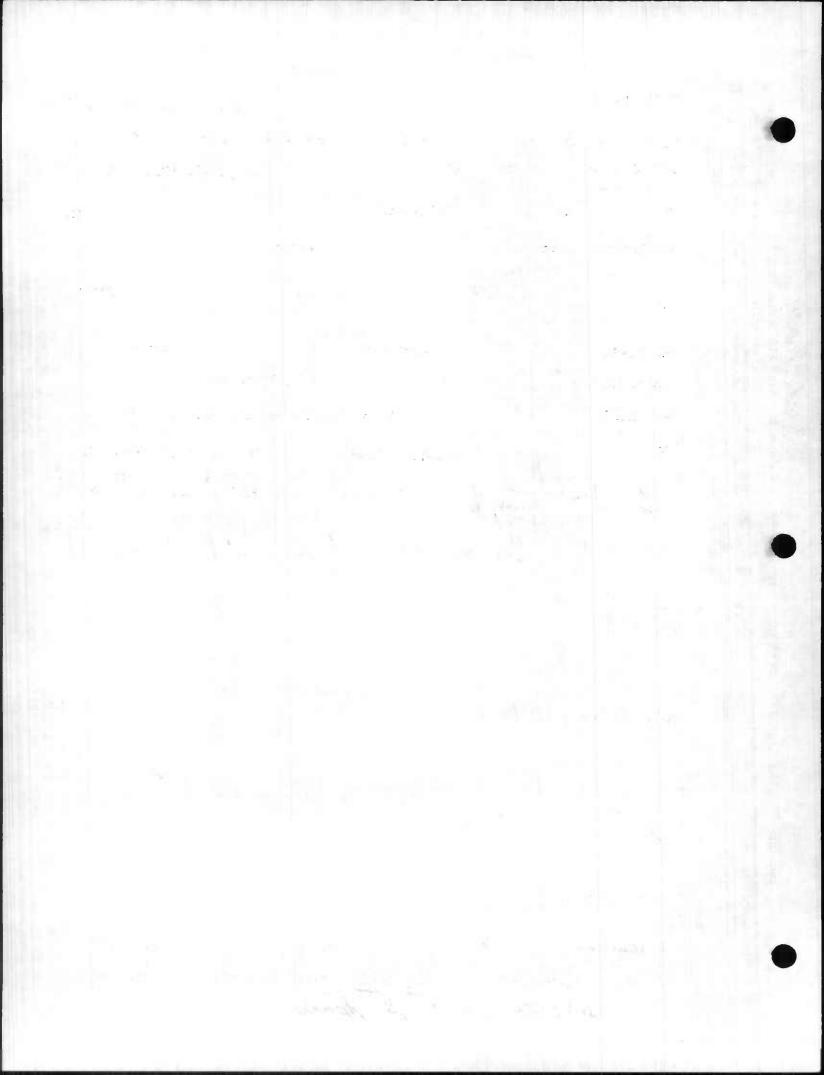
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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) and General Hospital . Pasmarthy, m.O. Co 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

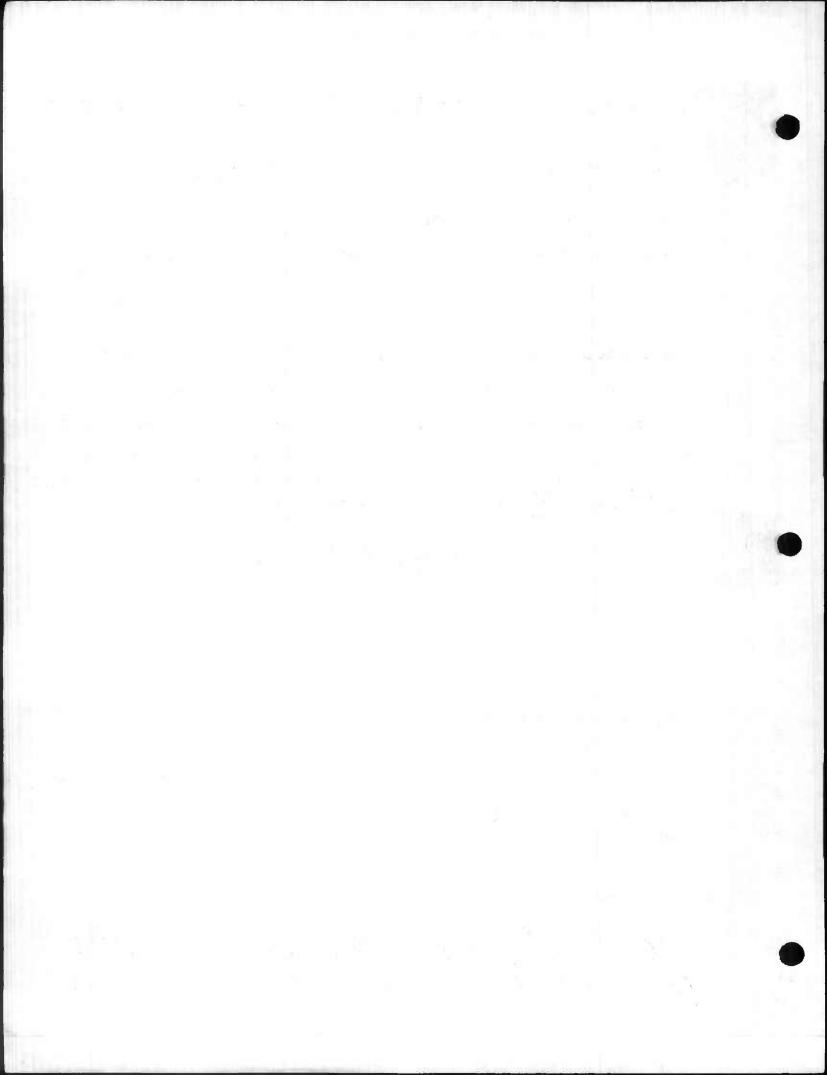


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Month 2158 Horace Lee May /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner for Haspital Baltimore Balti conse Samari (200d If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1∏M 2□F 216-16-3508 74 Yrs Director 12-05-24 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Mooical Examinet must be notified at MD Director NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5216 Kelway Road 21239 USA death 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritaf Status 14. Raca - Amarican Indian, Bleck, White, etc. 72 hours efter 1X Yas 2 No If Yes, Give 1 Never Marriad 2 X Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: Black r Yes, Give Year or Dates: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within 7 Depertment of Health and Mental Hyglena. Important: if lem 27 is marked other than "n any Injury or other traumatic avant Elementary/Secondery (0-12) College (1-4or 5+) 10th Grade Laborer Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be William Franklin Viola Nickolson 2 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Sally Franklin 5216 Kelway Road Baltimore, Maryland 21239 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MD Burial 2 Cremation 3 Removal from State Garrison Forest VA Cem. 05-17-99 Owings Mill, Donation 5 Other (Specify) 22. Nama and Addrass of Fecility appla of Funeral Servica Ligens Baltimore, Maryland 21202 0 WM.C.March FH 1101 E. North Avenue Part1. Enter the diseasa, or com shock, or heart failure. List only complications only one cause fons that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting In death) Cardiomyopathy ears Examiner Examiner bunel-transi Sequentielly list conditions, if any, leeding to Immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or as a consequence of) Box 68760. physician Physician/Medical the Dua to (or as a consequence of): esn ō Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the 3 Probably 4 Unknown 1 Tyes 2 No Coagulo puller toma Completed by 24b. Were eutopsy findings availabla prior to completion of cause of deeth? 24a. Was an eutopsy 2 No 1 Yes 1 Yes 25 No Hospital or Attanding Physician: 25. Was case referred to medicel examiner? Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No fal Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Panding Invastigation in 24 hours after death.

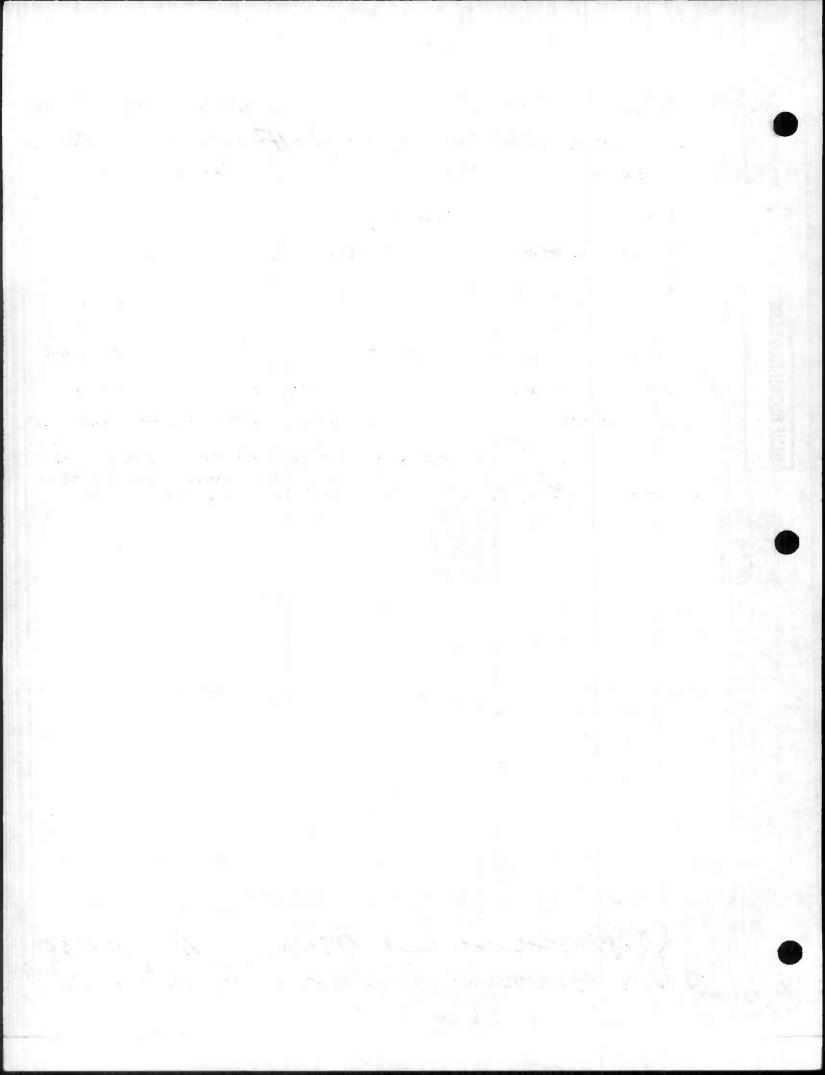
The Funeral Director: After pletaly filled in by tha fun 1 Yes 2 No 2 Accident 6 Coufd not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Certifier Medical 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mennar es stated. completaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. within 2 29b. Signature and title of certifies 29d. Data signad (Month, Day, Year) 09 30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print) Good Sameritan Kospilal, 5601 Loch Raver Block, Baltimore, Walter MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



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State of Maryland / Department of Health and Mental Hygiene

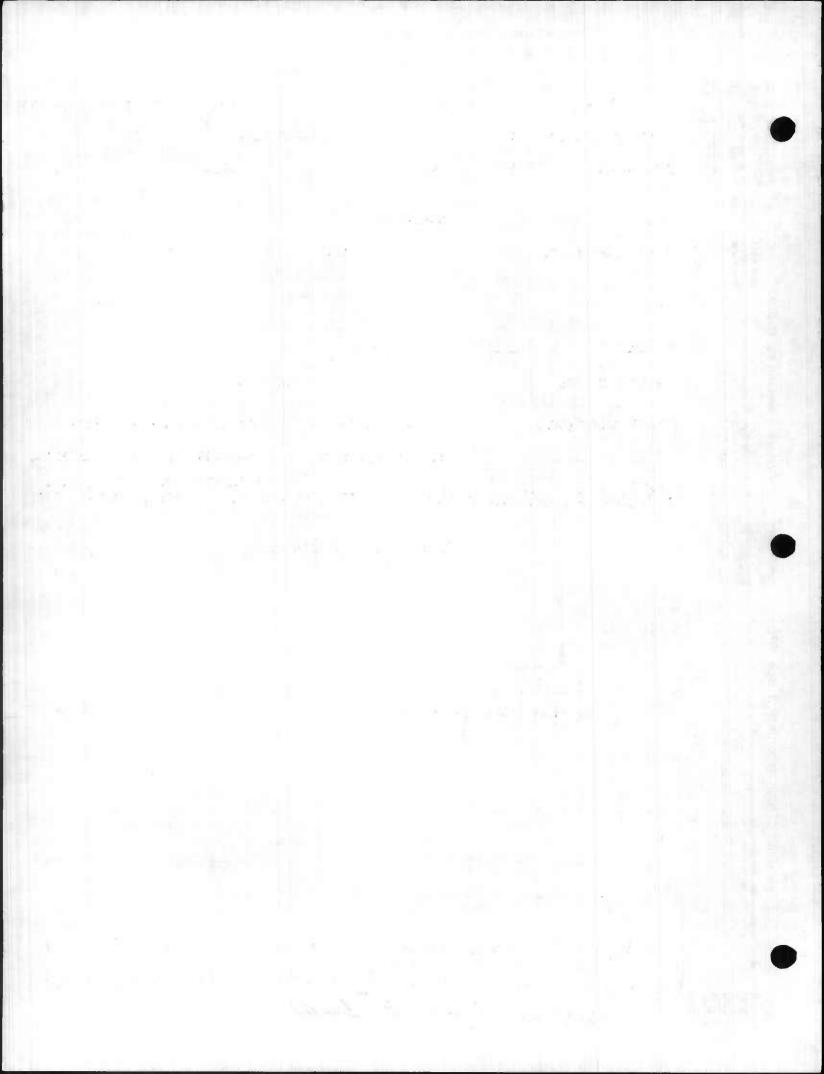
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THE DAY] Suicide] Homicide	determined	28e. Place o building	of Injury - At hor g, etc. (Specify)	no, farm, stre	et, factory, o	ffice	28f. Location City or To	(Straat and Numi	ber or Rural Rou	a Number,		
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To the Funeral Director: completely filled in by the Medical Certifical			1 Certifying Phy Medical Exami	sician: To the b ner: On the bas and manne	ils of examineti	riedge, deeth on end/or inv	occurred et estigation, in	he time, dete end pie my opinion, deeth oc	ece, and due to the courred at the time	cause(s) end ma , dete end piece,	anner as steted. end due to the c	ause(s)		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Ma U **Physician** 8:50pm TOSTER Vamil /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva streat end number) Examiner BON SECOUR HOSPITAL BALTIMORE N/A if Undar 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) 6. Sax Birthplace (State or Foreign Country) **Funeral** Months 1□ M 25 F Days 81 Yrs. VA. 229-09-8631 Director Usual Residence of Deceden with the Merylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at 1 Yas 2 No Director N/A BALTIMORE 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 1000 GILMORE ST. 21217 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐No If Yas, Giva Yaer or Dates: 13. Was Decedant of Hispanic Ongin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian. 11. Marital Status Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Inportant: If flem 27 is marked other than "natural", or her any injury or other treumatic event. 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) (Giva kind of work done during most of working lifa. DO NOT use ratired) Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) WALTER WALKER UNKNOWN 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Melling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) JAMES WALKER(SON) 525 SANFORD PLACE BALTIMORE, MARYLAND 21217 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata MT. ZION CEMETERY 5-13-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funeral Sarvice Licensaa PHILLIPS FUNERAL HOME, P.A. Dector CFSP 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Entar the disease, or complications that ceused the death. Do not antar the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onsat and Death Physician Preumonia day /Medical mration Immediata Causa (Final disaasa or conditio rasulting in daath) Examiner Examiner physician and the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate ceusa. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consaquance of): BSA for signed by the a Pert II. Other significant conditions contributing to death but/oft resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mcestive Wasta lurd þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was cesa rafarred to medicel examinar? Be 26. Place of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Mainpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 200 No To this 28c. Injury at Work? 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: After 5 Pending invastigation 1 Neturel death. 1 Yas 2 No 2 Accidant ofter death Director: 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, ferm, straet, factory, office building, atc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stata) 4 I Homicide n 24 hou. Funerel P Hospital 155 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the causa(s) and manner es stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end menner stated. 29a. Cartifian Medicai (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b Signatura and titla of pertifian 29c. Licensa number Medical House I hysician om 23a) (Typh, Print) Dognitz 2000 W. Baltimora ST. Baltimora, MD 21223 Name and a

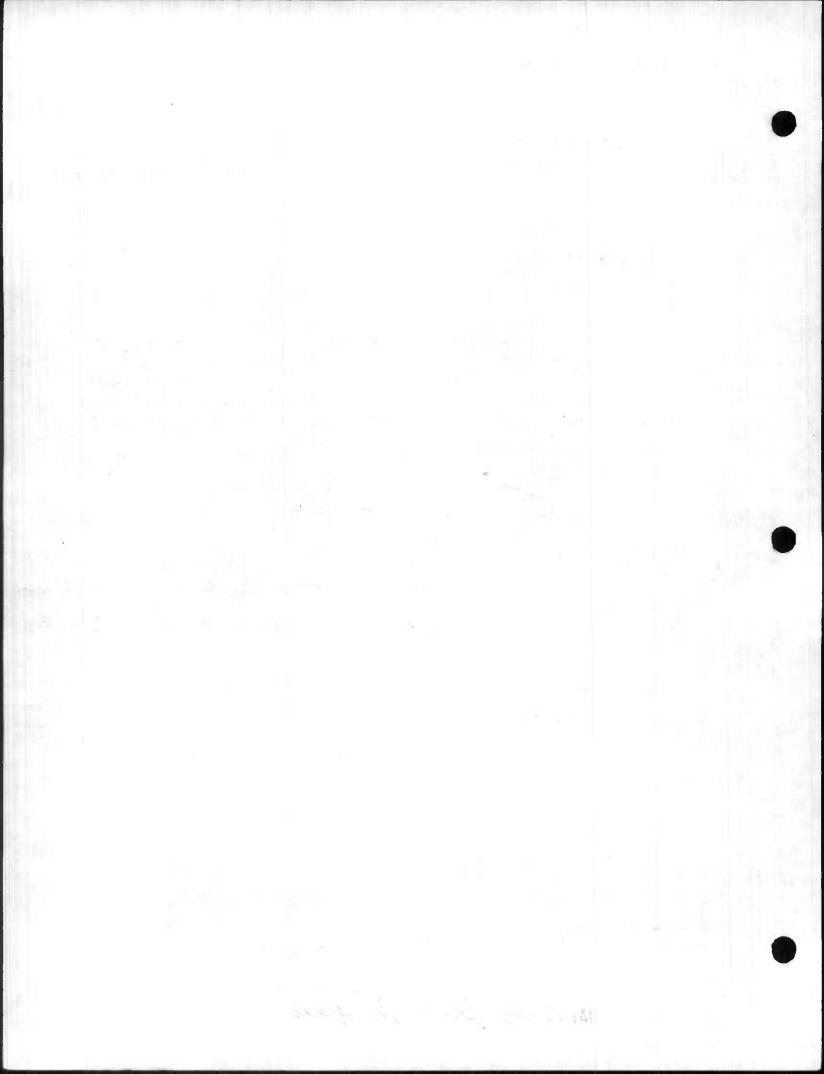
Sm Secours Hospital 32. Ragistrar's Signature

State Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	G771 5/13/99 EV		Cert	ificate of	Death	100-15	Reg. No."	10	000	
1. Decedent's Name (First, Mic	ddle, Last)					2. Date of De Month	Day Day	Year	3. Time of Death	
HENRY 4a Facility Name (If not institu	tion aire street and arm b	as)	FI	RIEDBERG		or Location of Deat		999	10:40PM	
		91)			LUTHERV		BALTI			
BRIGHTWOOD 5. Social Security Number		Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir			ce (State or Foreig	
215-22-5481	X□ M 2□ F	72		Months Days	Hours	Ain. (Month, Di	y, Year) 9 1927	Countr	y)	
Usual Residence of Decedent		1.4				UNAT	9 1921	MAR	YLAND	
10a. Stete 10b. Cour	nty	10c. City,	Town or Loca	ition				10	d. Inside City Limit	
	I/A		BALTI	MORE					Y☐Yes 2☐N	
10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Countr	y?	
6300 RED CF	DAR PLACE, I	NIT 40	6		1209			ISA		
11. Maritel Status	12. Was Decede Armed Force	s?	i. 13. Wa	as Decedent of lifes, specify Cub	Hispanic Origin oan, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	D- 14. Hac	e - America ck, White, el		
1 Never Merried XXX 3 Widowed 4 Divorce	If Was Give	□No	10	Yes 25 No	Specify:		Specify	· WH	ITE	
	dent's Education	5.	16a Deceder	nt's Heust Occu	nation		16b. Kind of Bu			
(Specify only hig	hest grade completed)		(Give kir	nd of work done NOT use retire	pation during most of ed)	working	Too. Kind of De	Jan Rodge II IOC	ao y	
Elementery/Secondery (0-12	2) Coilege (1-40 2	or 5+)		Propriet	or		Wholesal	e Food	a .	
17. Father's Name (First, Midd			- Mile	חחטטחח	18. Mother's	Neme (First, Middle			~	
JULIUS		FRIE	DBERG,	SR.	TI	HELMA		FOX		
19a. Informant's Neme/Reletic	onship (Type, Print)				t and Number o	r Rural Route Numb	er, City or Town,		Code)	
BARBARA FRIE	DBERG (WIFE)		6300 RI	ED CEDA	R PLACE	UNIT 40	6 BALT	0., M	D 21209	
20a. Method of Disposition		COL	ce of Disposit	ion (Name of tory or other pla	ice)	Date	20c. Location -			
1 M Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	on 3 Removal from Sta (Specify)	10	R SINA			12/99	OWINGS	MTLL	S. MD	
21. Signature of Fuguel Servi	or Donisee			Neme end Addre	ess of Fecility		ONTIVOD	11700	שניו ונ	
23a. Fert1. Enter the disease shock, or heart failure. L	14		5	SOL LEVI	INSON &	BROS., INC	2.			
disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	Due to (or	as a conseque	ence of):	hula	acida	ses .		Inkun	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequenca of):										
Part It. Other algnificant cond		becco use contribute to the cause of death								
	abeles									
							an autopsy ormed?	com	e autopsy findings lable prior to pletion of cause eath?	
						10	Yes 2 No	10	Yes 2□ No	
						Death (Check only	one)			
	cal			24.5	26. Place of	eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)				
25. Was case referred to medi axaminer? 1 ☐ Yes 2 ☑ No	Hospitel:	atient 2 E	R/Outpatient	3□ DOA Ot	hor /		idence 6 DOth	er (Specify)		
axaminer? 1 Yes 2 No 27. Manne of Death	Hospitel: 1 ☐ Inpe		28b. Time of	3LI DOA	her: 4 Nursir	ng Home 5 ☐ Res	idence 6 Oth how injury occur			
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pen 2 Accident Inve 3 Suicide 6 Cou	Hospitel: 1 □ Inpa 28a. Date of I (Month, I Id not be termined 28e. Placa of	njury Day Year)	28b. Time of Injury	28c. Inju	her: 4 Nursir	g Home 5 Res 28d. Describe		red		
axaminer? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pen Inve 3 Suicide 6 Cou dete 29a. Certifier 1 Certific (Check only 2 Medic	Hospitel: 1 Inp. 28a. Date of I (Month, stigation Id not be primined) 28e. Placa of building, ying Phyalclan: To the be all Examiner: On the basis	Injury - At hometc. (Specify) st of my knowled of examination	28b. Time of Injury	M 1 28c. Inju	her: 4 Nursir iny at ork?] Yes 2 No ime, date and p	28d. Describe 28f. Location (City or To	(Street and Numb wn, State)	per or <i>Flural</i>	Route Number, ted.	
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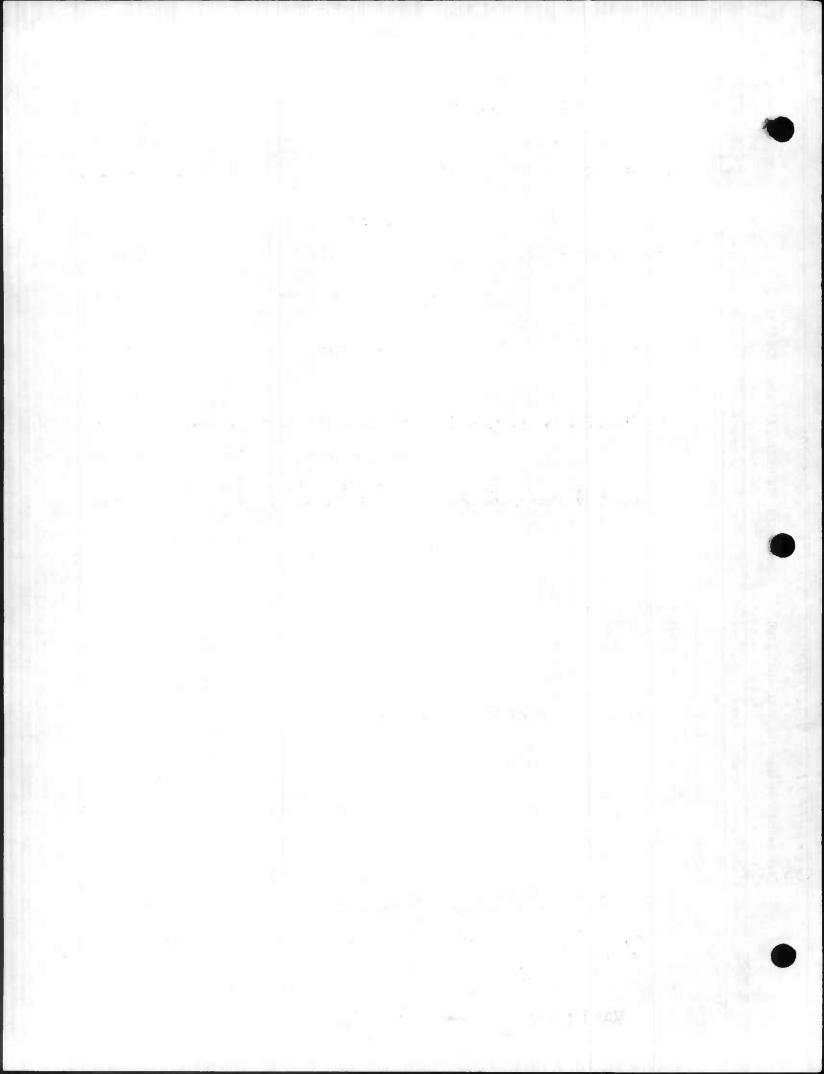
State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Adolph Peter Guraleczka May 11, 3:10 AM /Medical 4a Feclity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Gilchrist Center Baltimore Towson 8. Dete of Birth (Month, Dey, Year) May 9, 19 If Under 1 Yaar If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 100 M 2□ F Days Months Hours Min. 84 Yrs. 213-01-4869 Pennsylvania Director Usual Residence of Decedent the Merylenc 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location *naturat", or itema 23a or 28a-f ahor edical Example: must be notified at 1 Yas 2 No Directo Maryland Harford Fallston 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2506 Burgundy Drive 21047 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 M Yes 2 □ No It Yes, Give Year or Datas: WW II 14. Race - American Indien, Bleck, White, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced the Medical Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mentel hygiene. Important: If Item 27 is marked other than "re any Injury or other traumatic event, the Next Elementery/Secondery (0-12) College (1-4or 5+) Shipping Clerk 6th Grade Manufacturing 17. Fether'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Joseph Guraleczka Tekla (surname unknown) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2506 Burgundy Drive, Fallston, MD Danielle Peters (daughter) 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Parkwood Cemetery 5/14/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Eacility
Schumunek Funeral Home, Inc. 21. Signature of Funerel Service Licanses toward 1 9705 Belair Rd., Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Finel e demention 12ars disease or condition resulting in death) Examiner Physician/Medicai Examiner physician and s the buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in deeth) Lest Due to (or as a consequence of): Dua to (or as a consequence of) 89 attending p for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ArterydiseAse by 24b. Were eutopsy tindings available prior to completion of cause ot deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending 1 Yes 2 No investigation 6 Could not be detarmined 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and fittle of continue , uno 30. Name and eddress of person who completed cause of quality from 23a) (Type, Print) N. Charles St. Balto md 2120x GAMC 6701 Kiley 31. Dete tiled (Month, Dey, Year) 32. Registrar's Signeture

Registrar

MAY 12 1999

G. Sports

gurallesta, Adolph



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death 4e. Facility Nama (If not institution) and street and number) 3:45 AM 4b. City, Town, or Location of Death 4c. County of Death Baltimer Mercy Hospital If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Sacurity Number 9. Birthplaca (State or Foreign 7. Aga (In yrs. last birthdey) 1□M 2▼F Months Days 82 218.01.0139 Yrs 9-24.16 Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore (Md 1 Yas 2 No 10e. Straat end Numbar 10g. Citizen of What Country? HVENUE 21224 21. S. a. 2612 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Naver Married 2 Married Spacify: specify: White 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Brykowski OhN IGNES 19b. Meiling Address (Straat and Numbar o) Rural Route Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Joseph Baltimore Nd 21224 avenue 20a. Method of Disposition 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Ramoval from State 4 Donation 5 Othar (Specify) Baltimore, Md. Li Funeral Home P. Kailes ions that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest. Approximete Intarvel Between Onset and Death Immediata Causa (Finel disaesa or condition rasulting In death) Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaasa or injury that initieted avants rasulting in death) Last Dua to (or es a consequance of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 200No 1 Yas 21 No 1 Yas 25. Was case referred to medical examinar?
1 ☐ Yas 2 ☑ No 26. Pleca of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Invastigation 1 Yas 2 No

burial-transit and physiclan a the burial Box 68760. as 980 Records, P.O. 8 peen hes page 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director,

Physician /Medical

Examiner

Examiner Physician/Medical Completed Be

Physician

/Medical

Examiner

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylen Department of Healith and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28s-4 show any intry or other traumatte event, "In Medical Eduming ment be notified at

Baltimore, Maryland 21215-0020

by Medical Certification: To

1 Natural 2 Accidant 3 Suicida 4 Homlcida

29a. Cartifier

6 Could not be detarmined

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

2 Madicat Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified

124

12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceusa(s) and manner as stated.

29d. Date signed (Month, Dey, Year)

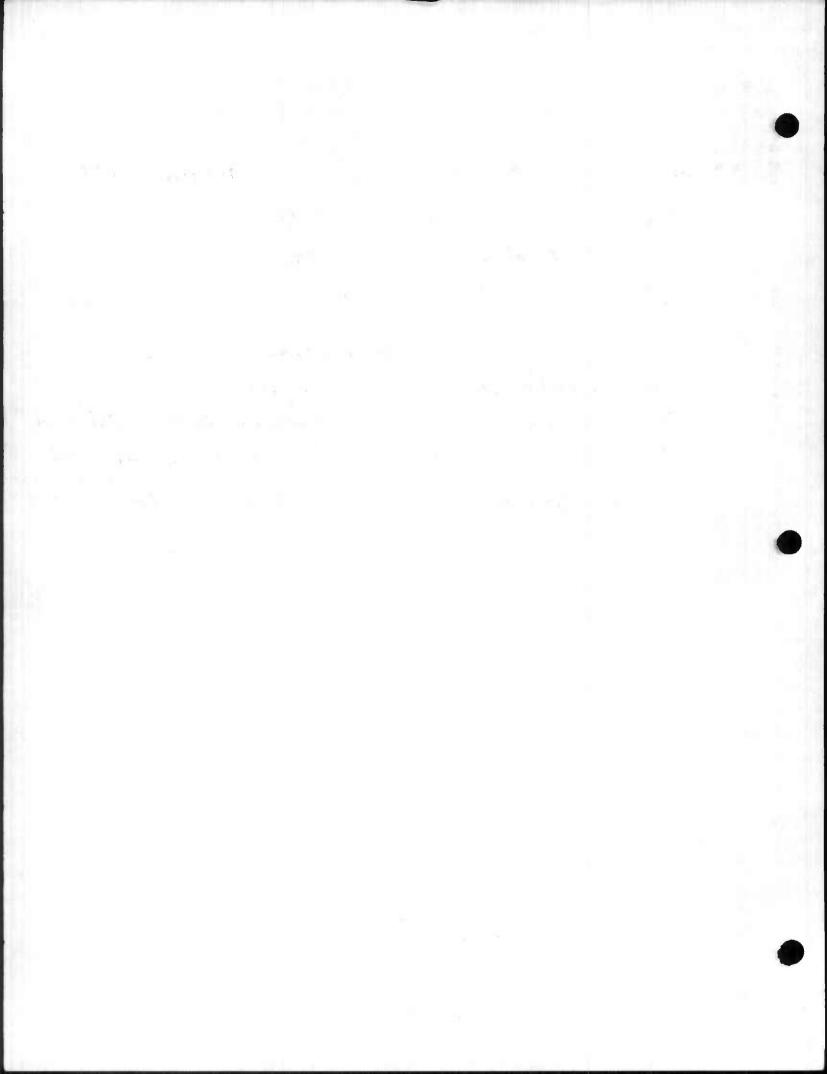
laudia 31. Dete filed (Month, Day, Year)

MD 32. Registrer's Signatura

MAY 1 2 1999

30. Name and eddress of person who completed causa of death (Item 23e) (Type, Print)

State Registrar

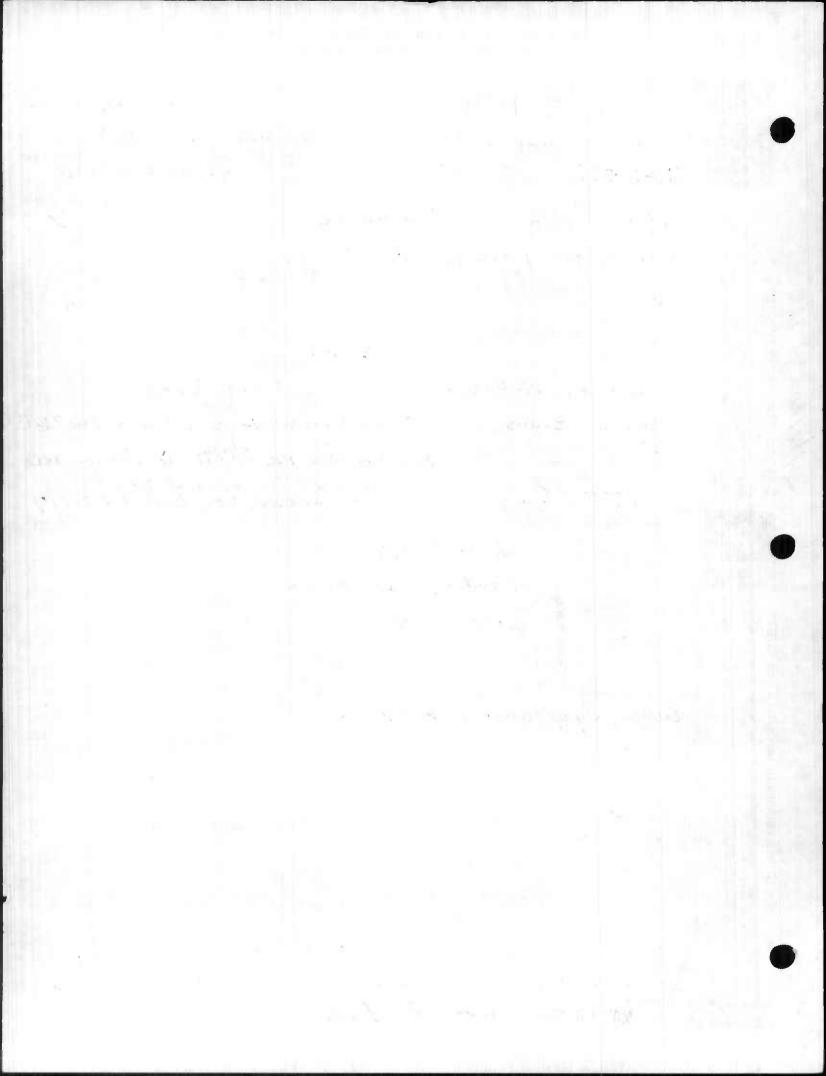


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Helen 4b. City, Town, or Location of Deeth PAIL + MORE CITY /Medical 4c. County of Deat 4a Facility Neme (If not institution, giva straet and number Examiner General Makyland
5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Months Days Hours Min. 4 - 24 - 15 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 F Z13-16-5310 Usual Residence of Decedent Yrs. MD Director with the Mendend 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f shot other treumstic event, the Madical Examiner must be notified at Baltimone 1 Tes 2 No MD Directo 10f. Zip Code 10e. Street end Numbe 10g. Citizen of Whet Country? Place-Apt. 708 1701 21217 Funeral 12. Wes Decedant Evar in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Detes: 13. Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: "natural", or Black 3 Widowed 4 □ Divorced p Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede complated) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) OFFICE permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: if item 27 is marked other that any injury or other treumatic event, 17%, 000. Clerk 18. Mother's Nama (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Brown W. Israel Mary James 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Longlook land, Columbia, MD 2,1045

me of Dete | 20c. Location - City or Town, Stete Evans Blanche Baltimore. 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Ramoval from State Arbutus Mem. PK 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Fecility
How P. Close 21. Signature of Runerel Service Licen Fineral Service 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart failure. List only one cause on each line. 2/2/7 Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner attending physician and for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Due to (or as e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ate hes been signed by the page 2 should be detached 3 Probably 4 Donknown tomatic 1 Yes 2 No Division of Vital Records, by 24b. Ware autopsy findings eveileble prior to completion of causa of death? 24e. Wes en eutopsy performed? Completed certificate hes 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours efter deeth.

To the Funeral Director: After this certifies 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yas 2□ No 10 funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. edical completely 2 Madical Examinar: On the basis of examinetion and/or invastigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Data signad (Month, Day, Year) 29b. Signeture end title of certifier 29c. Licanse number molo 30. Name end eddress of person, who completed cause of deeth (Item 23e) (Type, Print) 1777 Reisterstown Road Ste 60 Balto. md. Zachary Moko, M.D. 31. Dete tiled (Month, Dey, Year) 32, Registrer's Signature MAY 13 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death Reg. No.	10016
Physician	MACH TAYLOT MCTHZ	3. Time of Death 12:52 PM
/Medical Examiner	4a Facility Nama (If not institution, give street and number) 4b, City, Town, or Location of Death 4c, County of I	Death ltimore
uneral irector	5. Social Security Number 212-07-9709 6. Sex 1 M 2NF 88 Yrs. 7. Aga (In yrs. last birthday) 10 M 2NF 88 Yrs. 11 M 2NF 88 Yrs. 12 Months Days Hours Min. Sept. 22, 1910	Birthplace (State or Foreign Country) MID
M 18	10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits
to ot	MD Baltimore Towson	1 □ Yas 2 No
r 28	10e. Street and Number 10f. Zip Coda 10g. Citizan of Wha	t Country?
al D	800 Southerly Rd. #412 21286 US	A
Examiner must be notified at Examiner must be notified at by Funeral Director	3 Wildowed 4 Divorced Yaar or Datas: If Yas, Giva Yaar or Datas: Specify: Specify:	American Indian, White, atc. White
important: If item 27 is marked other than "natural", or any injury or other traumatic avent, the Medical Event page. To Be Completed by F	15. Decedent's Education (Specify only highast grada completed) Elamentary/Secondary (0-12) 10 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) Secretary Food	ass/Industry
F 0		
To Be	Curtis Oscar Taylor Ethel Brushmiller	
-	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Sta	ta, Zip Coda)
T the	Carl A. Heinz - Husband 800 Southerly Rd. #412 Towson,	MD 21286
otto	20a, Method of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - Cit	
Š	4 Donation 5 Other (Specify) ABARDOVAL from State Camaton, cramatory or other place) ge MD	
any union	21. Signature of Funaral Sarvice Licensee, Potent O. Mitchell—Wiedefeld Funeral H 6500 York Road, Baltimore, M	ome, Inc.
	23 on 1. Entar tha disaasa, or complications that ceusad tha daath. Do not enter the moda of dying, such as cardiac or respiretory arrest, mock, or heart failura. List only one ceuse on each line.	Approximeta Interval Batween
an al er	Immediata Causa (Final diseasa or condition rasulting in death) Dua to (or as a consequence of):	Onset and Death 2 WEEKS
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sicie	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributions.	bute to the cause of death'
d be detached for use d by Physician/M		Probably 4 Unknow
plete	24a. Was en eutopsy performed?	4b. Ware autopsy findings available prior to completion of causa of death?
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completely filled in by the funeral director, Medical Certification: To Be (Specify)
Certification:	3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)	or Rural Routa Number,
Medical Certifi		er as stated. due to tha cause(s)
×		fonth, Day, Year)
	30. Name and address of person the completed ceuse of death (Item 23a) (Type, Print) BEATRIZ F. DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204	+
State Registrar	MAY 1 9 1000	

State of Maryland / Department of Health and Mental Hygiene

							Cei	rtificate	of	Death		Reg.	No.		
			1. Decedent's Name (First, M	liddle, Las	st)						2. Date of	Death			3. Time of Deeth
	ysicia	_	ELIZABETH			HATLE					Month MAY		Day	Year 1999	5:15 AM
6.7	ledic	-	4a. Facility Neme (If not institution, give street end number)						-	4b. City, Town, o					J.13 AM
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bug *		1	10e. State 10b. Co			10c. C	ity. Town or Lo	cation						10	d. Inside City Limits
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mit. Pages 1 and 2 should be filed within 72 hours after death with partment of Health and Mental Hygiena.	6		1 Burial 2 □ Cremati	ob 3 [V	Removal from		cemetery, cren	netory or oth	er ple	ca)	Date	200	. Location -	City or Fow	m, State
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Dhuala	ion		23a. Pert1. Enter the disease shock, or haart tailure.	List only o	one cause on e	ach line.			v. uj	·g, 000/. 00 00/.0	o on roop water	y arrost,			Interval Between Onset end Deeth
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Attending or death.		Certification	3 ☐ Suicide 6 ☐ Cor	id not be	28a Diaco	of Injury At 6	ome torm at			20110	294 League	n /Strac	t and M	or or Desert	Pouto Mumb
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30. Name and address of person who completed causa ot death (Item 23a) (Type, Print)

29c. License number D19667

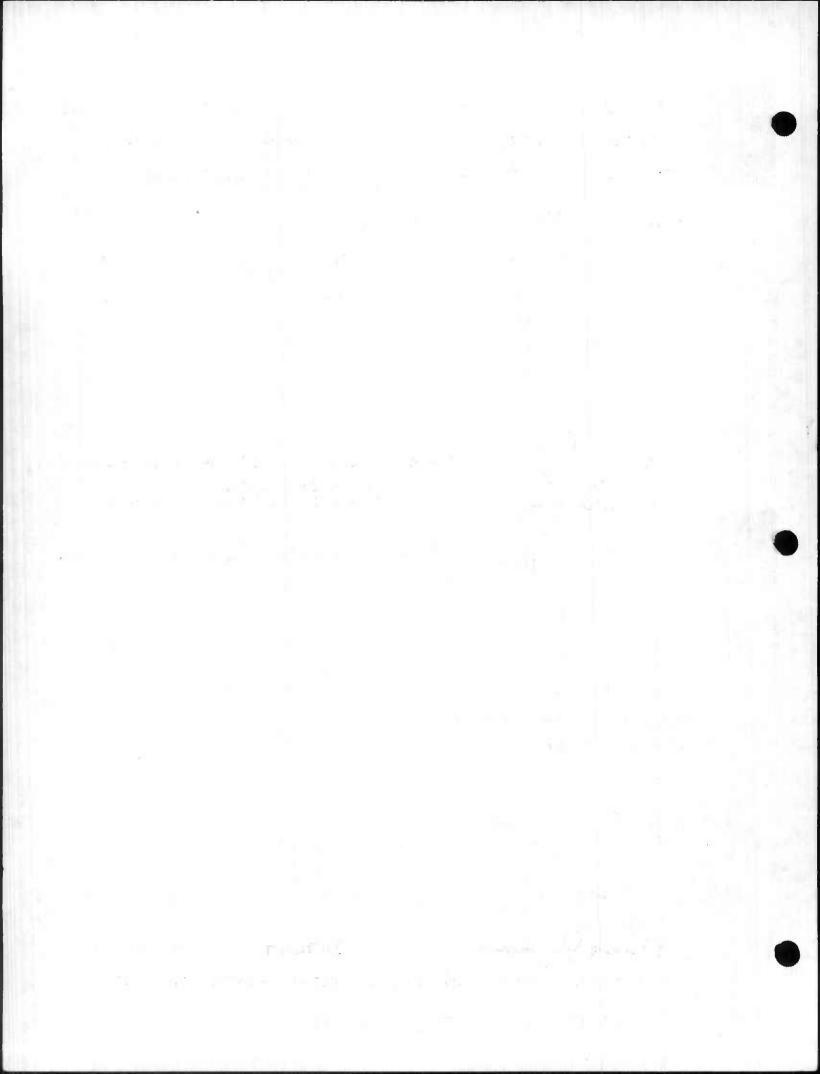
29d. Date signed (Month, Dey, Yaer)

5517 "A" RITCHIE HIGHWAY BALTIMORE MD. DR. MICHAEL SCHWARTZ

31. Date tiled (Month, Day, Yeer) State Registrar

29b. Signeture end title of cartifier

32. Ragistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Juanita Johnson Month **Physician** 3:10pm May 8, 1999 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor Nursing Home Catonsville Baltimore 5. Social Security Number 212-20-6625 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 29, 1918 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) Va. **Funeral** 1□ M 212117 80 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location Baltimore 10a, Stata Md • 10b. County 10d. Inside City Limits worle ! r than "natural", or Nems 23s or 28s-f shores n/a 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3303 Wilkens Avenue 21229 USA Funeral deeth Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Nevar Marriad 2 Married Specify: Black 21215-0020 1 Yes 20 No Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If flem 27 le marked other than ary or other treumatic event, ma Ma Elementary/Secondery (0-12) College (1-4or 5+) Physical Therapist Kennedy Institute 9th Grade Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be James Johnson Jeanette Marshall 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5 Winkel Court Apt. 3D Baltimore, Md. 21237 19e. Intormant's Name/Relationship (Type, Print) Theodore L. Johnson 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burlal 2 Cremation 3 Removal from State permit. Pege Department of Important: If eny Injury or pace. Woodlawn Cemetery May 14 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signaturado Funeral Service Licanse 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part. Enter the disease, or complications the/caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart tailure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** CONGESTIVE HEART FAILURE /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC or Attending Physicien; The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 No IN FUMON 1A 3 Probably 4 Unknown Records, should be þ DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No certificate Division of Vital funeral director. 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 5 Residence 6 Other (Specify) 1 Yas 12 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital **Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Surjet A julke ms 821 N. EUTAW ST, BALTIMORE MD 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JULKA M.D. MAY 1 2 1999 A Proposition of the state of t 31. Data filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month HORACE KEES 48 Facility Name (If not institution, give street end number) 12:30 AM MAY of Death 4b. City, Town, or Location 4c. County of Death Church Home Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days Hours Months 150 ★ 2 F 44 215-60-4390 Aug. 15, 1954 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a **Baltimore** XIX Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 N. Douglass Court 21202 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ ★es 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Biack, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 NO Specify: 3 Widowed 4 Divorced Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman K & S Paints 12th Grade 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Meiden Sumeme) Horace Kees Lucille Jones 19a. Informent's Name/Reletionship (Type, Print) Wife Cynthia G. Kees 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 611 Caton Avenue Baltimore, Md. 21218 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State th Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forrest Veterans///ay// Owings Mills, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Em 23a. Part f. Enter the disease, or complications that could be death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or hear feilure. List only one ceuse on an inferior. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATO-RENAL SYNDROME Due to (or as a consequence of): ONE WEEK ATIC FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

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Certification: To

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Hygiene.

pernit. Pages 1 and 2 should be filled. Department of Health and Mental Hygis Important: If Item 27 is marked other: any injury or other traumatic event. E

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760. Records, P.O. Completed certificate Division of Vital ä Affior or Attending

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes ZNO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Pate of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Siatural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stefed. 29a. Certifier

within 24 hours after death. To the Funeral Director: A

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State

HOSPITAL 31. Date filed (Month, Dey, Year) MAY 12

290. Signature and the of pertifier

(Check only one)

N BROADWAY 100 32. Registrar's Signature

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BALTIMORE

29c. License number

D0046029

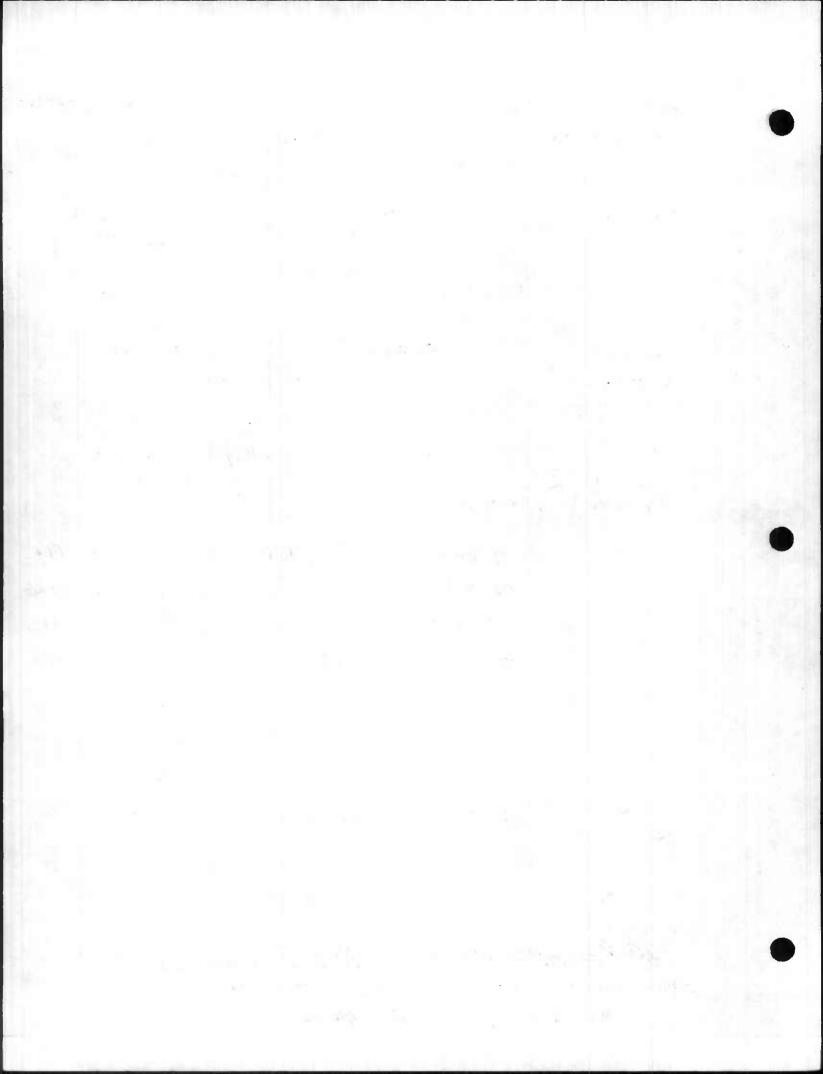
29d. Date signed (Month, Dey, Year)

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Registrar

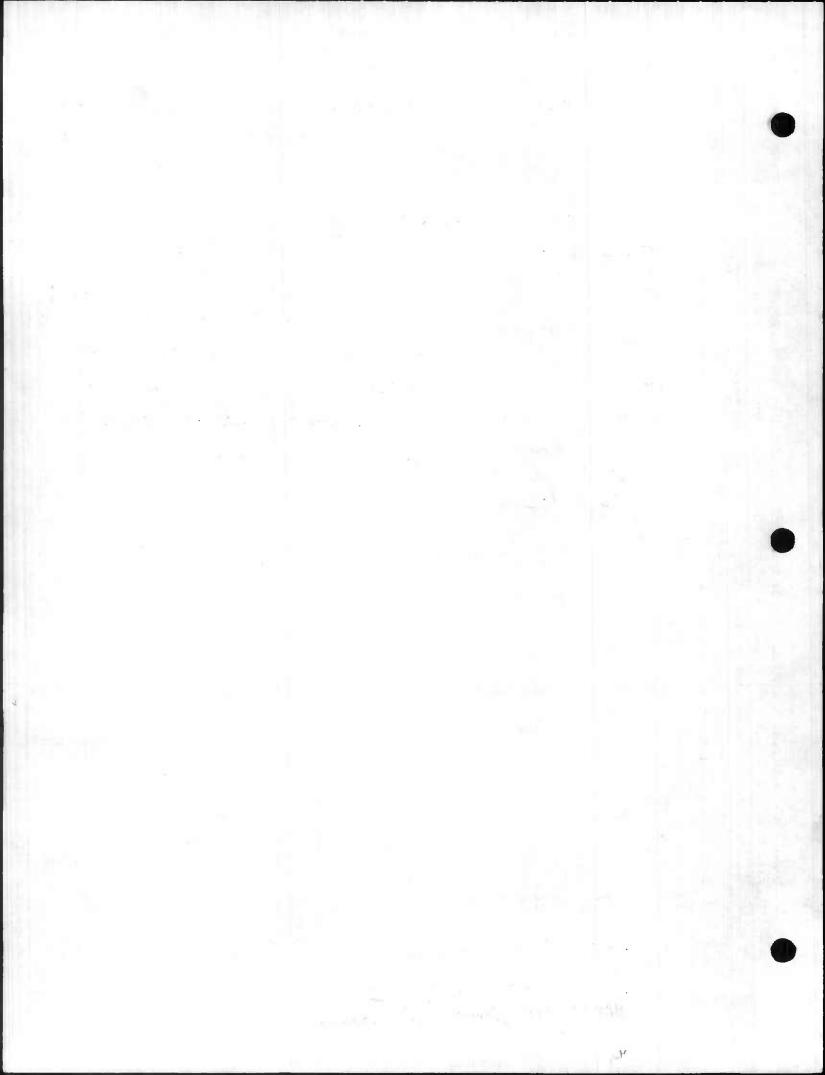
and address of person who completed ceuse of death (Item 23a) (Type, Print) ABDUL K. GARUBA, MD.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** STANLEY KATZENSTEIN MAY 9, 1999 9:12 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2401 BRIARWOOD ROAD BALTIMORE N/A If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Year) APR. 7, 1940 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours 1X M 2□ F 216-36-3341 59 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or hams 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2401 BRIARWOOD ROAD 21209 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Marriad 2 X Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify. WHITE p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Thygiens. Elementary/Secondary (0-12) Collega (1-4or 5+) 7 PROPRIETOR PICTURE FRAMING 17. Father's Name (First Middle Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Be iit. Pages 1 and 2 should be authorit of Health and Mental orland: If them 27 is marked of LUDWIG KATZENSTEIN **GERTRUDE** BACHENHEIMER 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY KATZENSTEIN / WIFE 2401 BRIARWOOD ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from Steta 4 □ Donation 5 □ Other (Specify) WOODLAWN CEMETERY 5/11/99 WOODLAWN, MD 22. Nama end Addrass of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fernanciarvice Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 a for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Lupe c METS 7 mos Examiner Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): physician a Box 68760. Physician/Medical Dua to (or as a consequence of): signed by the a P.0. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? SZY+s 2 No 3 Probably 4 Unknown Records, py 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? Completed peed 188 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 5 24 hours e Hospital 29e. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated. edical (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. within 2 29b. Signature and fittle of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JOHN LAVIN - 660 KENILWORTH DR. #202 - TOWSON, MD 21204 @ WEST ROAD 32. Ragistrar's Signetur State Registra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month 1999 MAY 10. GRACE M. KESSLER 4:30 P.M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death CATONSVILLE BALTIMORE GENEISIS ELDERCARE CATONSVILLE COMMONS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 1□M 2X F Days 214-03-0913 APRIL 14,1906 93 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No BALTIMORE MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 134 1st AVENUE 21227 14. Raca - American Indian, Black, Whita, atc. 11 Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 1 ☐ Naver Married 2 ☐ Married 1 Yas 2♥ No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedant's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Elamentary/Secondery (0-12) College (1-4or 5+) OWN HOME 8TH GRADE HOMEMAKER 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) CLARA HOFFMAN WALTER FALLON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Code) 134 1ST AVENUE - BALTIMORE, MARYLAND WALTER D. SMITH, SR. (FRIEND) 20b. Placa of Disposition (Nama of camatery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Namoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 5/13/99 WOODLAWN CEMETERY 21. Signature of Funaral Sarvice Licensaa 22. Nama and Address of Facility HUBBARD FUNERAL HOME, INC. tronder Foreign Trong Tr 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 End JA age Chamic Obstructure Palmong Diene Due to (or as a consequence of): Immediata Causa (Final disaase or condition rasulting In death) Sequantially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Disaasa or Injury that Initiated evants resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24e. Wes an autopsy performed? Ware autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa refarred to medical axaminar? 26. Place of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify)

Physician /Medicai **Examiner**

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Depertment of important: If any injury or once.

Physician

Examiner

Funeral

Director

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traumatic event, the Medical Examiner

filed within 72 hours efter

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Maryland

Baltimore,

Director

Funeral

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nerai Director: After this y filled in by the funerel di

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The law requires that the death certificete be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

To the Hospital within 24 hours a To the Funeral C

Physician/Medical þ Completed Be Certification: To

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1 Yas 2 No 27. Mennar of Death 14 Naturel 2 Accidant 3 ☐ Suicida

29a. Certifier

4 ☐ Homloide

6 Could not be

28a. Data of Injury (Month, Day Year) 5 Panding investigation

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of 28c. Injury at Work?

1 Yas 2 No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how Injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and plece, end due to the ceuse(s) and manner as stated.
2 Madical Examinar: On the best of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, end due to the ceuse(s) and manner stated.

29b. Signature and titla of cartifier

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29c. Licensa number

29d. Data signed (Month, Day, Year)

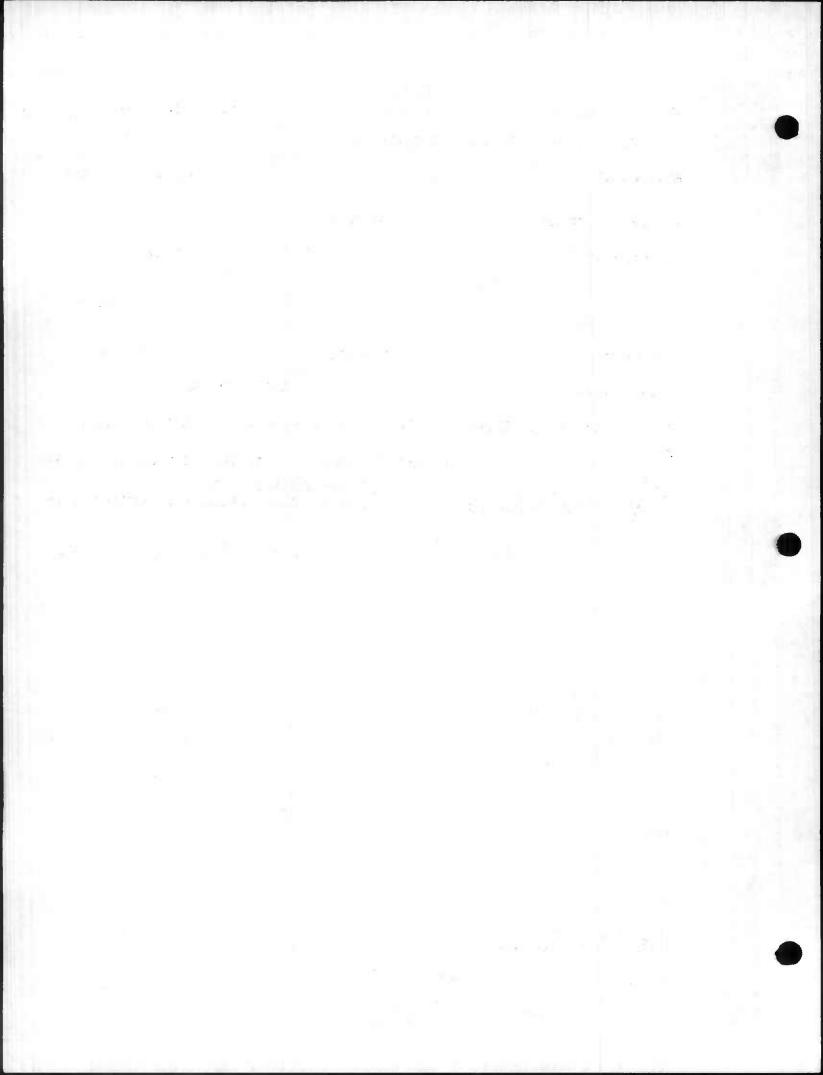
30. Name and addrass of person who completed cause of deeth (Itam 23a) Type, Print, EDM NO A TRACKLE 405 Freder L

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Registrar

31. DMAY 13 D1999

32. Registrar's Signatura

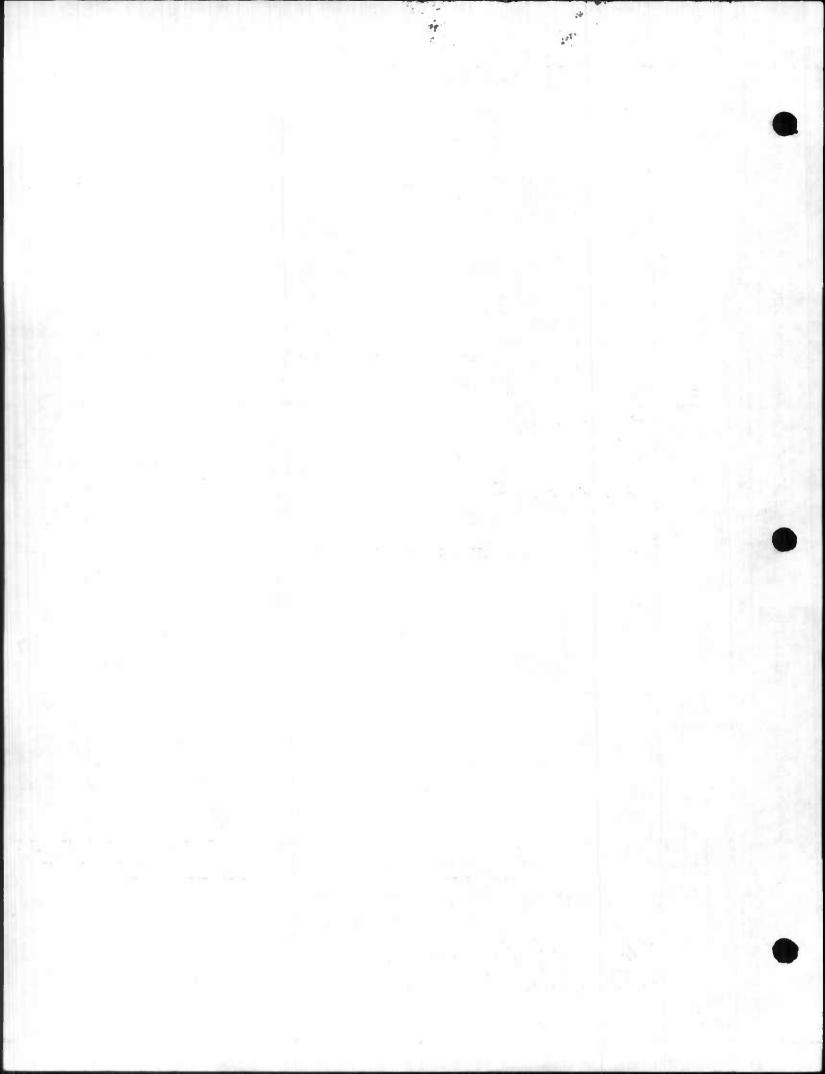


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DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month MA 1999 GUAN JIE LAI 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street end number) 4c. County of Death BALTIMORE CITY STELLA MARIS @ MERCY HOSPITAL If Undar 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) APRIL 4, 1915 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthpleca (Stete or Foreign Deys Hours 1X M 2 □ F 84 Yrs. CHINA 220.06.0303 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 333 EAST NORTH AVE 21202 CHINA 12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) ASSISTANT RESTAURANT 6 17. Fathar's Nama (First, Middle, Last) YI SAU LAI 18. Mother's Name (First, Middle, Maiden Sumeme) FOUNG CHEUNG 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) QIANG ZHEN LAI WIFE 333 EAST NORTH AVE BALTIMORE, MD 21202 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY 5.12.99 GLEN BURNIE, MD 22. Name end Address of Fecility FINK FUNERAL HOME, PA. KELLY GREGORY) 426 CRAIN HWY. SW. GLEN BURNIE, MD 21061 FINK 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Finat disaase or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or trijury that initieted events resulting in death) Lest Due to (or es e consequence of): Dua to (or as a consaquance of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings avelleble prior to 24a. Wes en eutopsy completion of causa of death? 200 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) STENIA MARIS AT MERCY Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE 1 Yes 20 No 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how Injury occurred 27. Menner of Death 28e. Date of injury (Month, Dey Yeer) 28b Time of 28c. Injury et Work? 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

ettending physician and for use as the bunal-transit that the death cartificete be executed Division of Vital Records, P.O. Box 68760, SB signed by the a page 2 has certificate director,

Physician Medical

Examiner

Hospital or Attending Physician: After this funeral aftar death. Director: Aft

Physician

/Medical

Examiner

Director

Funeral

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Examiner

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Certification:

Medical

29a. Certifier (Check only one)

29b. Signature and title of certified

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or herms 22s ~ ^ ^ ^ ^ ^ ^ ~ ...

State Registrar

DERG 32. Registrar's Signeture

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30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Till Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

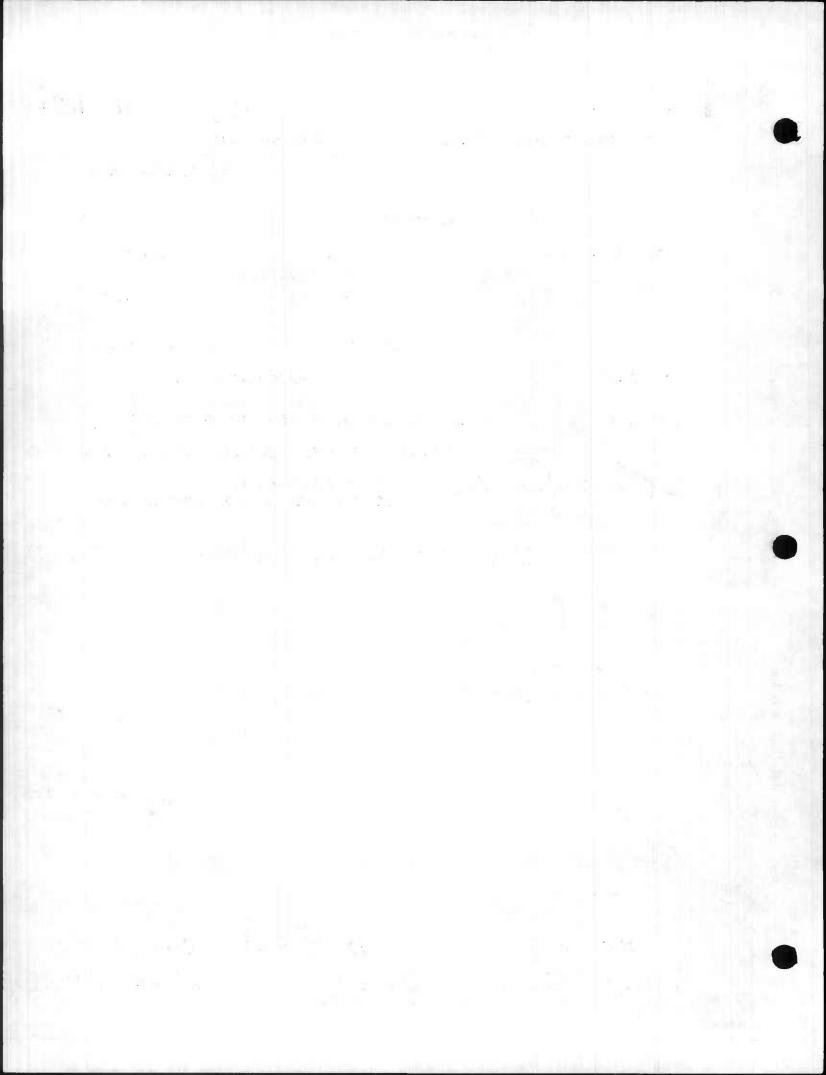
29c. License number

29d. Dete signed (Month, Dey, Year)

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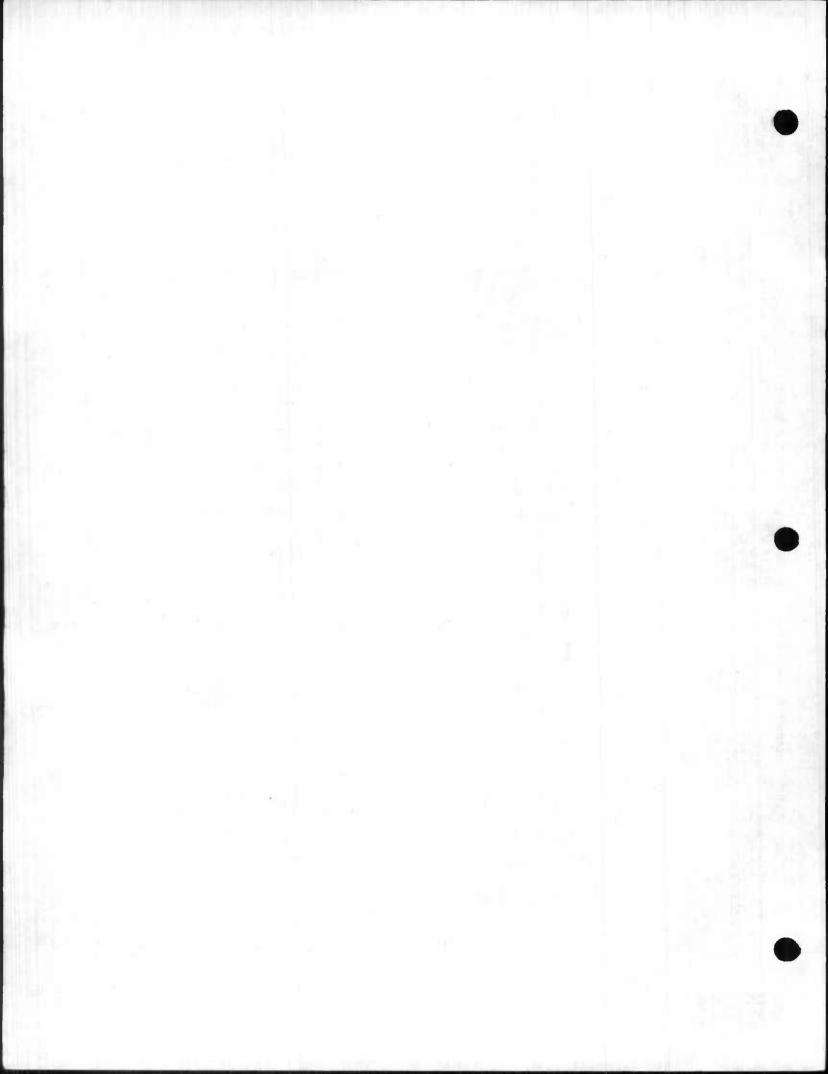
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	Certificate of Death	Reg. No.	15620			
	1. Decedent's Nama (First, Middla, Last)	2. Dete of Death Month Day	3. Tima of Death			
Physician /Medical Examiner	JEANETTE FRISCH MOORE	May 10, 1999	9:20 P.M.			
LAMITHIE	GENESIS ELDERCARE AT BRIGHTWOOD Lutherv					
Funeral Director	5. Social Security Number 6. Sex 1		9. Birthplace (State or Foreign Country) Maryland			
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he M	Maryland N/A Baltimore	10- 000	21			
th with	10e. Street and Number 10f. Zip Code 21212		USA			
20 8 -18 30	If Yes, Giva 1 ☐ Yes 2 ☑ No Specify: 1 ☐ Yes 2 ☑ No Specify:	pecify Yas or No- lo Rican, atc.) 14. Rac Blac Specify	e-Amaricen Indian, ck, White, etc. White			
72 hours "natural".	15. Decedent's Education (Specify only highest grada completed) (Giva kind of work done during most of workifa. DO NOT use retired)	rking 16b. Kind of B	usiness/Industry			
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2 should and Men and Men e marks	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Ri		State, Zip Code)			
Pages 1 and nent of Healt int: If Healt inty or other	Norma J. Moore (Daughter) 20a. Mathod of Disposition 1 Burial 2 Cramefion 3 Removal from Stata 4 Donation 5 Other (Specify) 21. Signature of Disposition (Nama of cematary, cramatory or other place) Woodlawn Cemetery 22. Nema and Address of Facility		City or Town, Stata			
Baltirr permit. Pa Departmen Important: any Injury once.	21. Signature of Funeral Service Logistee 22. Nema and Address of Facility Mitchell 1 - Via od of old	d Eunoral Homo	Tno			
8	Martin Dawson 6500 York Road Bases, or complications that ceused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiretory errest,	Approximate Interval Between			
Physician /Medical Examiner	Immediata Causa (Final disease or condition rasulting in death) a. Due 10 (or #4) a consequence of):	ne	Onset and Death Www.			
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death cer estending for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h. Did tobacco una co	ntribute to the cause of death?			
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aw requires to show the special specia		24a. Was an autopsy performed?	24b. Wara autopsy findings svailable prior to completion of causa of death?			
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Of Vita Physician: this certific ratification.	1 Yes 20 No Hospital: 1 I Innetient 2 FR/Outpetient 30 DOA Other: 4 Dispersion by	loma 5 ☐ Rasidence 6 ☐ Oth	nar (Specify)			
Vision of Attending Pt or death. or death. or death. by the funeral iffication:		28d. Describe how injury occur	red			
Division of standing P after death. The Director: After to de in by the funers Certification:	3 Suicida 4 Homicide 6 Could not be detarmined 28e. Piece of Injury - At home, farm, sfreef, factory, office building, atc. (Specify)	28f. Location (Street and Numb City or Town, Stata)	ber or Rural Routa Number,			
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com						
To the somple	29b. Signature and title of smile 29c. License number		od (Month, Day, Year)			
	D2756	55	hu 155			
	30. Name and address of person who completed ceusa of death (Itam 23a) (Type, Print)	nee Rd #	32B			
State Registrar	31. Data filed (Month, Pay Year) 32. Registrar's Signatura for 13					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Defe of Deeth 3. Time of Deeth **Physician** William J. Murphy /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De Examiner Baltimore N/A Stella Maris Hospice at Mercy Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer 5. Soctel Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days 167-18-5055 Pennsylvania May 21, 1921 Director Usuat Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Instde City Limits ms 23a or 28a-f show 1 Yes 2 No Baltimore Perry Hall Maryland Directo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 21128 U.S.A. 4309 Piney Park Road Funeral 12. Wes Decedent Ever in U,S. Agned Forces? 1 № Yes 2 □ No If Yes, Give Year or Dates: than "natural", or items the Medical Examiner on 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) 12th Grade College (1-4or 5+) Bank Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gertrude Schick Joseph J. Murphu 19e. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4309 Piney Park Rd., Perry Hall, MD 21128 Mrs. Trudy Brewer (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 5/12/99 Baltimore, Maryland Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feither. List only one cause of each line. 9705 Belair Rd., Baltimore, MD Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Finat disease or condition resulting In deeth) /iviedical Metostatic Bladder Cancer Examiner Examiner the buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that Initieted events resulting in deeth) Last Due to (or as a consequence of): pue Physician/Medical Due to (or as e consequence of) 98 950 Pert II. Other significant conditions contributing to deeth buf not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive Pulmonary disrase 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? page 2 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificete To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Wes case referred to medicet 26. Place of Deeth (Check only one TE //A MARIS AT MERCY Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28c. Injury et Work? 27. Manner of Death 28e. Dete of Injury (Month, Dev Yeer) 28b. Time of 28d. Describe how Injury occurred Certification: Naturel 5 Pending investigation 2 Accident 3 Sulcide 6 Could not be 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et fhe time, dete end plece, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examtnetion end/or investigation, in my optnton, death occurred et the time, date and place, end due to the cause(s) and manner steted. 29a, Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

certificate be executed Division of Vital Records, P.O. Box 68760,

the Marylend

Wordowy William,

State Registrar

Marin 31. Date filed (Month, Day, Year)

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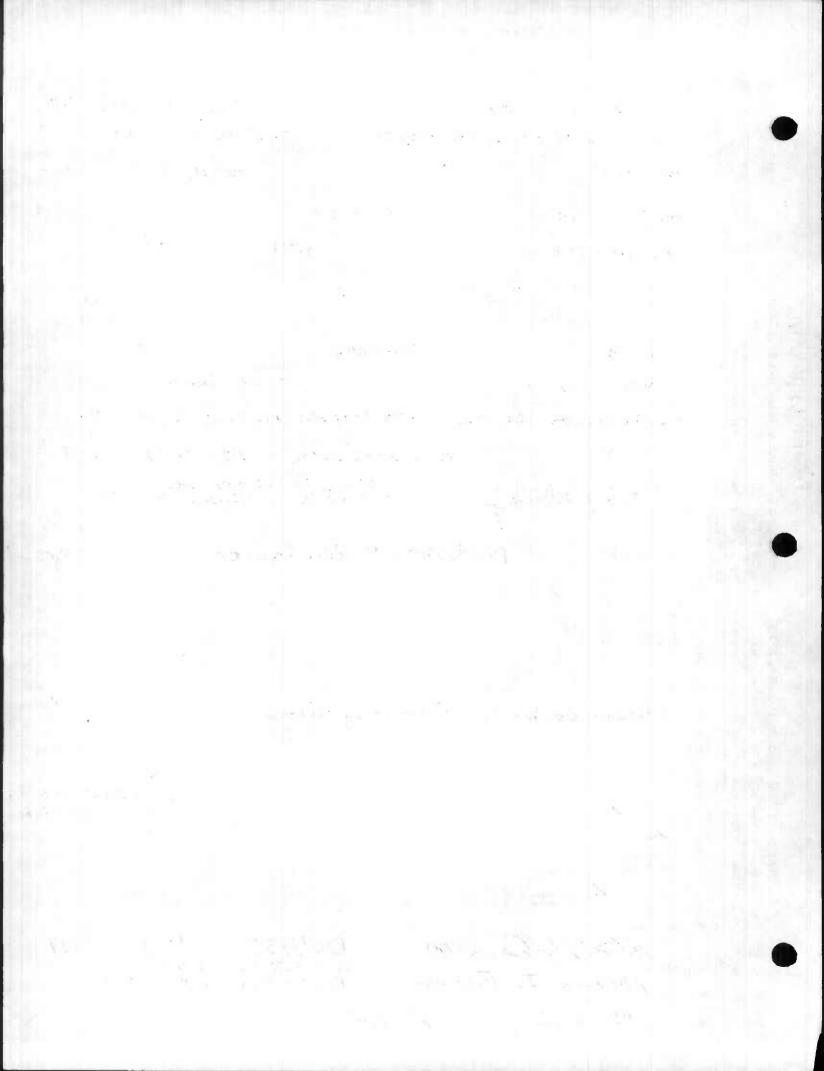
e/d may 32. Registrar's Signature

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

301 St. Paul Place Baltimore, Md, 21202

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may



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15622

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	Funeral Director		5. Social Sacurity Number 220 – 30 – 3549		°X □ M 2XX	7. Age 93	(In yrs. last birt	rs.	If Under 1 Ye Months De		Hours Min.	8. Date of Bir (Month, Da Oct. 8,	y, Year)	05	9. Birthpli Count Es	aca (Stata or I ry) tonia	Foreign
	land ow		Usual Residence of Deced 10a. State 10b. 0	County			10c. City, Town	or Loca	ation						10	d. Inside City	Limits
	Mery H sh	tor	Maryland	N/A				Bal:	timore							1 Yes 2	≥□ No
	th the	Director	10e. Street and Number					0000	10f. Zip Cod	de			10g. Cit	tizen of V	Vhat Count	ry?	
	th wil		3515 Erdman	Avenu	e.					21	213		и.	S.	A.		
	r dea	Funeral	11. Marital Status		12. Was Dec Armed Fo	edent Evorces?	ver In U,S.	13. W			ispanic Origin? (Sp in, Mexicen, Puerto	ecify Yes or No		14. Raci	e - America k, White, e		
Maryland 21215-0020	within 72 hours after death with the Meryland ene. than "natural", or items 23a or 28a-f show ha Medical Examiner must be notited at	by	1 ☐ Never Married 2[3 🛱 Widowed 4 ☐ Dir	_	d 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas:			1 ☐ Yes 2X No			Specify:	rinoari, oto.)	Specific			ite.	
5-0	hin 72 ho a. In "netur Medical	Completed	15. De	cedant's Edu	ucetion fa completed)		16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine							sinass/ind	ustry	
121	within ene. then	mple	Elamentary/Secondary (College (-)						Housekeeping					
7	filed with Hygiene. ort, the		Unknown	fiddle (act)				1	Housek	.ee		a (Einak Adialalla				.ng	
and	S de de	17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Leese Petail 19a. Informant's Name/Relationship (Type, Print) Luardian Wanda Blackwell Representative 1000 Cathedral Street, Baltimore								Journam	8)						
IZ.	d 2 should by	ĭ			voe Print).		19h	Meiling	Address (Str	reet s				or Town	State Zin	Code	
	t Till		Wanda Blacku	088	uardia Poproso	n	tive 1				ıl Street						01
	- PEE		20a. Mathod of Disposition				20b. Place of	Disposi		f		Date			City or Tov		
E	Pages nent of I ant: if ite ary or of		1 Burial 2 Cram 4 Donation 5 Ot			Stata			6 Fait		,	5/12/99	Bal	timo	no. N	larulan	ıd
Baltimore,	in the state of		21. Signatura of Funeral S	ervice Licens	800			22	Name and Ad	ddres	s of Facility				, ,,,	or egrecie	· LUL
m	Dep Impo		Burn (LLO	LO 2010	2					Funeral to s Lane, 1			Mary	Pand	01012	
П	-	-	23a. Part1. Enter the disea shock, or heart failure	sa, or comp	licetions that one cause on e	caused ti	ha daath. Do n	ot enter	the moda of	dyin	g, such as cerdiac	or raspiratory a	rest,	muty		Approximata Interval Betwe	een
'n	Physician					\circ										Onset and De	eath
	/Medical Examiner		Immediata Cause (Final disaasa or condition resulting in death)		a	KE	SPIRA	101	RY t	A	HLURE	=			1		
		-e													1		
	uted	Examiner			b	OK	ON A	4	AR	16	ERY E	20216	AS	E			
Ć.	execution and inel-tra	Exa	Sequentially list conditions if any, leading to immediat cause. Enter Undarlying Cause (Disease or injury	ė		(2)					,				1		
68760,	ficete be executed physician and is the buriel-transit	edical	Cause (Disease or Injury that Initiated events resulting in death) Last C. Due to (or as a consequence of):														
	CD 65									RE				i			
Box	attendin for use	Physician/M			d	/(C	(4)/ (mic						1		
P.0.	the a	ysic	Part II. Other significant co	onditiona co	ntributing to d	aath but	not resulting In	tha und	derlying ceuse	give	en in Pert i.	23b. Dtd	tobacco	uae cor	tribute to	the cause of	death?
	requires thet the death cert ween signed by the attendin hould be deteched for use	by Ph	PERI	PHE	RAL	V	ASCU	LA	R	D	ISCEASE	= 10	Yes 2	2□ No	3 Prob	ably 4 Duf	hknown
rds	quires n sign	d b	0-		_							24a. Was		psy	24b. Wei	re autopsy find	dings
000		plet	2 EVE	-Ke-	et	NE	MIA	•				perio	rmed?		COFF	ilabla prior to apletion of ceu aath?	J\$8
R	6 4 6	Completed										10	res 2	DNo		Yes 200	6
ita	ician: The certificate rector, pag	Be C	25. Was case raferred to m	edicel						-	26. Place of Deat					.00 2,51	
f <	5 00	ToE	examiner? 1 Yas 2 No	1	Hospital:	Inpatient	t 2 ER/Out	patient	3□ DOA	Othe				6 Othe	er (Specify))	
U O	Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 □ I	anding	28a. Date (Mon	of Injury th, Day		ime of	28c. l	Injury Work		28d. Describe I					
sio	eath. or: A	catl	2 Accident	nvestigation Could not be							Yes 2 No						
Division of Vital Records,	To the Hospital or Attending Phywithin 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	Certification:		datamined	28a. Place buildi	of Injury ing, atc.	y - At home, far (Specify)	m, stree	et, factory, offi	ice		281. Location (3 City or Tox	Street ar vn, State	n <i>d Numb</i> i e)	er or Rura!	Routa Numbe	9F,
_	spital ours meral filled		29a. Cartifiar	rtifylna Phy	atcian: To the	best of	my knowledge	death c	occurred at the	a tim	ne, date and place,	and due to the	callea/s	and ma	nner se ete	ated	
	n 24 h	edicai	(Check only 2 Me	dicat Exami	ner: On the band man	asis of a	xamination and	Vor inva	stigation, In m	ny op	olnion, daath occur	red at the tima,	data and	d place, a	and due to	the causa(s)	
	To the To the Comp	Σ	29b. Signatupe and title of	prtition	1				29c. Lic	ense	number		29d. Da	ite signed	(Month, D	lay, Year)	
			Jans -	CV	3HA	LOD)	44)		D.	5	2228		5	1111.	59		
			30. Nama and address of p	erson who co	ompleted ceus	sa of das	ath (Item 23a) (1	Гуре, Р	rint)					1	1		
			Mariner Hea	eth o	6 Overl	lea,	6116 B	ela	ir Road	d-	Baltimor	e, Mary	lan	d 21:	206		
	Sta Registr		31. Data filad (Month, Day,	rear)	32. R	egistra	SSignatura	1	9. de	200	els						
	ricgisti	un	M	AY IZ	וסטט	1		1									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 -eN 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Cromwell Center Towson Baltimore 5. Social Security Number If Under 1 Months Hours Min. 8. Date of Birth (Month, Dey, Year) 6 Sex 7. Aga (In yrs. lest birthday) Birthpiaca (Stete or Foreign Country) 1□ M 2√F Days 219-10-3194 Yrs March 25, 1922 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐No Marvland Baltimore Phoenix 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 2828 Paper Mill Road 21131 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2/2 No If Yes, Give Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck. White, atc. 1 ☐ Never Married 2 ☐ Married 1 Yes XX No Specify: 3 Widowed 4 Divorced White 16e. Decadant's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) 12 Clerk U.S.Postal Service 17, Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Joseph Juskevickas Veronica Skelpsa 19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Son Gary Navickas 2828 Paper Mill Road Phoenix Md 21131 20b. Placa of Disposition (Neme of cematery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 □ Burial 2 IX Cremetion 3 □ Ramoval from Stete 5/14/99 Baltimore, Maryland Greenmount Cemetery □ Donetion 5 □ Other (Specify) 22. Name and Addrass of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, of complications that caused the daeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or haart failure. List only ona ceuse on aech lina. Immediate Cause (Final ALZHEIMER'S DISEASE disaese or condition resulting in death) Dua to (or as e consequance of): PPO THYROIDISM Sequentielly list conditions, if eny, leeding to Immediate cause. Entar Underlying Ceuse (Diseasa or injury that initieted evants resulting in deeth) Lest TO THRIVE FAILURE Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24e. Wes en eutopsy performed? 24b. Wera autopsy findings available prior to completion of causa of daeth? 1 Yas 20 No 1 Yas 2 No 25. Wes casa raferred to medical axeminer? 26. Place of Deeth (Check only ona)

Physician /Medicai Examiner

that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician:

The law requires

Hospitai

the state

permit. Pages Department of Important: If it any injury or o

Physiclan

/Medical

Examiner

Funeral

Director

28a-f show

6

items 23a

Pages 1 and 2 should be filed within 72 hours efter on of Health and Mental thygiene.
Int: if item 27 is marked other than "natural", or item
Inty or other traumatic event, the Medical Expanner
Iny or other traumatic event, the Medical Expanner.

Baltimore, Maryland 21215-0020

Directo

Funeral

by

Completed

traumatic event, the Medical Exanginer must be notified at

the Maryland

Examiner burial-transit and physician the 98 950 been signed by the should be detached page 2 this certificate director, Certification: To nours efter death.

neral Director: After this of filled in by the funeral director. within 24 hours e To the Funeral C completely filled

Physician/Medicai

by Be Completed

29a, Cartifier

1 Yas 2 DN6

27. Menner of Deeth

1 Naturel 2 Accident

3 Suicide

4 ☐ Homicida

5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Dey Year)

V. BHALODIYA

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Pieca of Injury - At home, farm, straet, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yas 2 No

28d. Dascribe how Injury occurred

28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete) 1 Certifying Physician: To the bast of my knowledge, daath occurred at the time, date end piece, and due to the ceusa(s) and mannar as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and this of cartifier

29c. Licensa number

29d. Data signed (Month, Dey, Yaar)

BALTIMORE 21214

30. Nema and eddrass of person who complated cause of deeth (Itam 23e) (Type, Print)

VIPULKUMAR BHACODIYA, MD 3007 E. NORTHERN PKWY

State Registrar

cal

31. Date filed (Month, Day, Yaar) MAY 1 3 1999

32. Registrer's Signatur

Leave Higher House

P.M.

04:55

MAY 10,1999

19	Sta Registra	
A	DHMH 16 Rev 6/95	5

	ITEM: # 2	PEF	R MD G771 G771 5-25-99 W		nd / Department of Certificate			ene g. No.	9 15	624			
1	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) MARY AGNES 4e. Facility Nama (# not institution, giva s Stella Maris Hosp	NEVILLE street and number)		4b. City, Town, or Loc	2. Data of Deeth Month April 4		Yeer 	ime of Death: 55PM			
	Funeral Director		5. Sociel Security Number 6. Sex 215-07-8040 1□ Usual Residance of Decedent	7. Age (in yrs.	Yrs. Months D	Year if Under 24 Hrs.	8. Data of Birth (Month, Day, December 3	Year)		State or Foreign			
	h the Marylend or 28a-1 show	Director	Maryland Baltimor 10e. Street and Number		nonium 10f. Zip Co	ode	10	g. Citizen of W	11	side City Limits Yes 2 No			
020	within 72 hours efter deeth with the Maryland ane. than "natural", or items 23s or 28s-f show he Moulcal Exprine must be notified at	by Funeral D	2300 Dulaney Valle 11. Marital Status XX Nevar Married 2 Married 3 Widowed 4 Divorcad	By Road 12. Was Decedent Ever in U Armed Forces? 1 Yes XX No If Yes, Give Yaar or Dates:	2109 7,S. 13. Was Decedan If Yes, specify	t of Hispanic Origin? (Spe Cuban, Maxican, Puarto F	cify Yas or No- Rican, atc.)		e - Amarican Ind k, White, etc.				
21215-00	77 75 1	Completed	15. Decedent's Educ (Specify only highast grada Eiamantary/Secondary (0-12) 12	cation	life. DO NOT use	tone during most of working	ng 1	6b. Kind of Bu	siness/Industry				
Baltimore, Maryland 21215-0020	ges 1 end 2 should be filed t of Health end Mental Hygis If Item 27 is marked other or other traumatic event, I	To Be C	17. Fether's Name (First, Middle, Last) James Patrick Nevi 19a. informant's Name/Ralationship (Typ.			18. Mother's Name Mary Agr	nes Grif	eidan Sumam fith	Θ))			
			M. Patricia Woodal 20a. Method of Disposition 1XX Deurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	l Niece	7001 Copele Place of Disposition (Name commetery, cremetory or othe v Cathedral C	igh Road Bal orphoce) emetery 5/	timore,	Maryla Oc. Location -	and 2121 City or Town, S	12 tate			
Ba	Department Department Important: any injury and injury		21 Ignature of Funaral Service Licanse 23a. Part1. Enter the disease, of complic shock, or heart failure. List only on	en Kenak	(A) 6500 Yor	k Road Balti	chell-Wied more, M raspiratory arre	aryland	21212 Appr inten	oximata val Batween et and Death			
	/Medical Examiner	Jer	Immediata Causa (Final disease or condition resulting in death)	Due to (c	trokes due		alized	sis					
Box 68760,	death certificate be executed e ettending physician end of for use es the buriel-transit	To Be Completed by Physician/Medica	To Be Completed by Physician/Medical	by Physician/Medical	cai	Sequentially list conditions, if any, leeding to immediata causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest		or as a consequence of):					
P.O.	0 0 0				Part II. Other significant conditions continue on the Dementia	tributing to death but not res	ulting in the underlying caus	se given In Pert I.		s 2 No		ause of death	
Record	2 5 5				ompieted					24a. Was en perform		avallable complati of death	on of causa
vision of Vita	or Attending Physician: iffer death. Director: After this certifica in by the funeral director,			25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Mannar of Death 1. Platurai 5 Pending Investigation 3 Suicida 6 Could not be determined	28a. Data of Injury (Month, Day Year)	ome, farm, streat, factory, o	Work? 1 ☐ Yes 2 ☐ No	(Check only one	nca 6 Other	er <i>(Specify)</i> ed			
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical Ce	(Check only 22 Medical Examinone) 29b. Signature and after of entitled	Ician: To the best of my kno er: On the basis of examina end manner stated.	tion and/or Investigation, in	my opinion, death occurre	d et tha tima, da	ta and place, a	nnar as statad. and due to the c				
	Sta	te	30. Name end address of person who cor DR EDDIE NAKE 31. Date flied (Monto, Day, Year)		n 23a) (Type, Print) DULANEY V		TIMONI	UM,MD					

Marine the Landerine

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amended#18 perFH G771 5/13/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month NARLINES 10 /Medical ROSE MAY 1999 8:32PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 1500 BEDFORD ROAD BALTIMORE 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number Birthplece (Stete or Foreign Country) **Funeral** 1□M 2XF Months Deys 214-76-3216 Yrs. Director 90 MAR. 4, 1909 MARYLAND Usuei Residence of Decedent the Marylend 10e. Stete ms 23a or 28a-f show 10b. County 10c. City, Town or Locetion 10d. Inside City Limits Director 1 ☐ Yes 🌪 ☐ No MD BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citlzen of Whet Country? #215

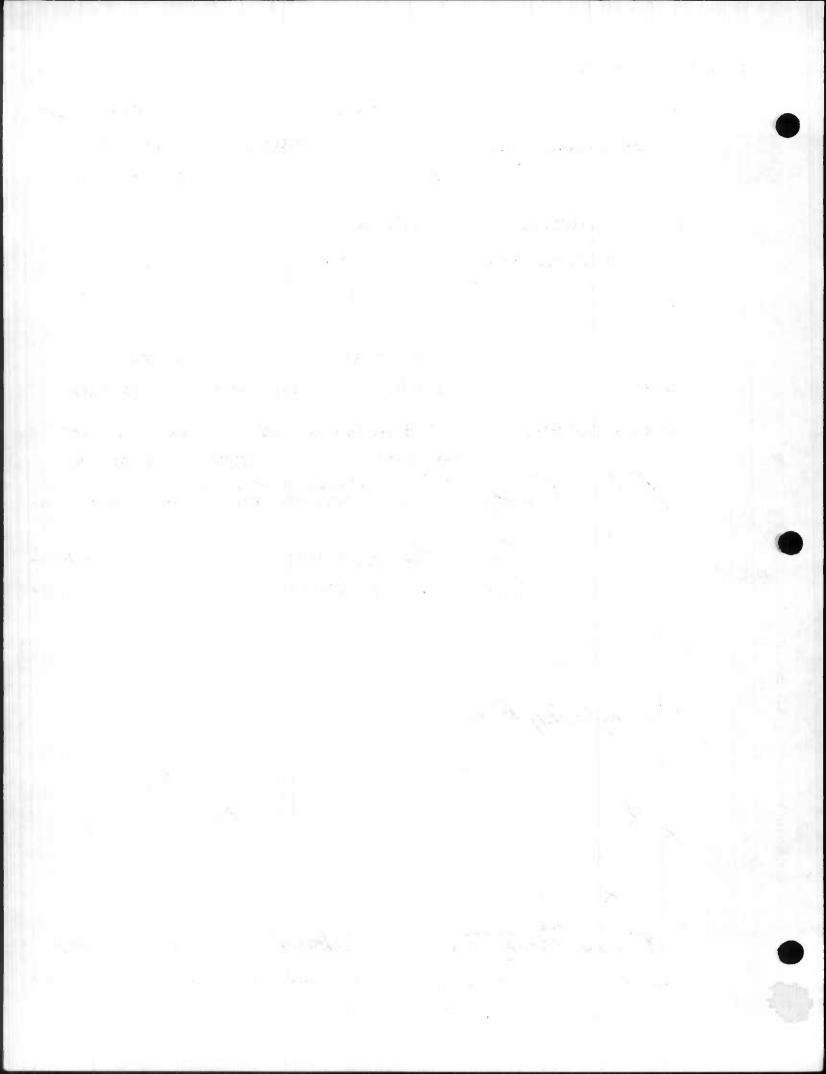
12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 Wo o If Yes, Give Yeer or Detes: Funeral 1500 BEDFORD RD. 21208

13. Wes Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Itams ; 11. Maritei Status r than "natural", or itan Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2X No Specify: WHITE Completed by 3X Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER marked other OWN HOME altimore, Maryland 17. Fether's Name (First, Middle | Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be . Peges 1 end 2 should be fit ment of Health end Mental H tant: If Itam 27 Is marked out jury or other traumatic evar 0 LOUIS **EPSTEIN** IDA Epstein EPSSTEIN 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BARRY NARLINES (SON)
20a. Method of Disposition 20b. Place of Disposition (Name of ST., APT. 2112 20 BALTO On MD Town State 2 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or 5 Other (Specify) BNAI ISRAEL 5/12/99 BALTIMORE, MD 21. Signature Fungal Service Lice 2. Name end Address of Fecility
SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner uscleutes The law requires that the death certificate be executed bunel-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest pue Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Se esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes & No 3 Probably 4 Unknown Records, þ pe Completed 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? director, page 2 should 24e. Wes en autopsy performed? 2 2 No After this certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 \sum Nursing Home Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yes 50 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 28b. Time of Naturei 5 Pending Investigation 1 ☐ Yes 2 ☐ No s efter death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours of Funaral D Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Exeminer: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner steted. 29a. Certifier To the Hosp within 24 hor To the Funa completely fi 29c. License number

D 18604 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Yeer) 30. Name end eddress of person who completed ause of death (Item 23e) (Type, Print) N. EUTAW ST # 202 BOTHMENE MD 2120) ROHALD S. POTOTSKY M.D. 821 32. Registrar's Signeture 31, Dete filed (Month, Day, Year) State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** MAY 1999 10 8 PM FRANCES NATHAN /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 F Yrs. Director <u>215–22–2563</u> JUNE 1, 1927 MARYLAND Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director BALTO. BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itema 23a 21207 6833 PARSONS AVE Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Stetus Peges 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yas, Give Yeer or Detes: 1 Nevar Married Married altimore, Maryland 21215-0020 "naturel", or 1 ☐ Yas 2 ☐ No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) OWN HOME 10 HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fil.
Department of Heelth and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event Be 2 **ABRAHAM** SCHWARTZMAN TDA GLASSMAN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE NATHAN (HUS.) 6833 PARSONS AVE. BALTIMORE, MD 21207 20b. Ptece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Duriel 2 □ Cremetion 3 □ Removel from State 4 Donation 5 ☐ Other (Specify) HEBREW FRIENDSHIP 5/12/99 BALTIMORE, MD 21. Signeture of Funeral Service Licensee 22. Nama end Address of Fecility SOL LEVINSON & BROS., INC. Approximate OO REISTERSTOWN RD PIKESVILLE, MD ter the mode of dying, such as cardiac of respiratory arrest. 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not shock, or heart feilure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immedieta Causa (Final disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or thijury that initiated events resulting In deeth) Last Box 68760, Physician/Medical Due to (or es e consequence of): **USB 85** P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been signed should be det Records, À 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy page 2 1 Yes 2 H 1 Yes 2 No certificate Division of Vital the Hospital or Attending Physician: Thin 24 hours efter death.

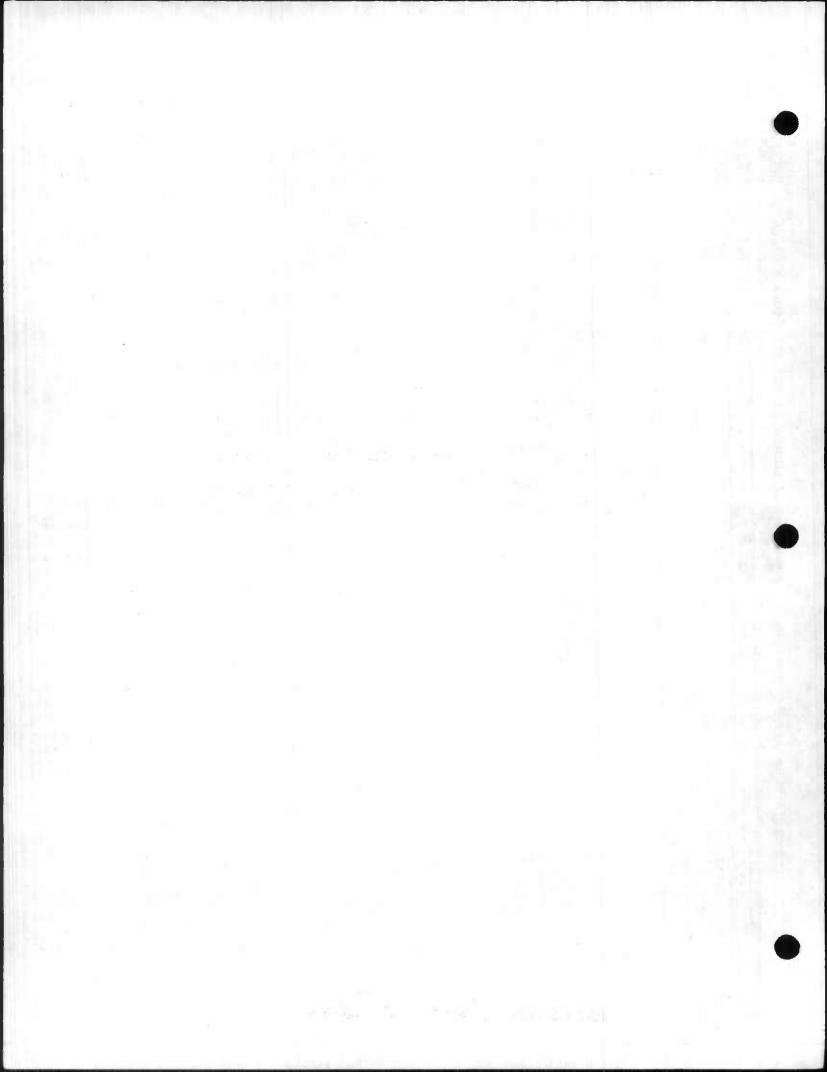
the Funeral Director: After this certifical mpletely filled in by the funeral director; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 (PNetural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Pteca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29e Certifier 29b. Signatura and tilla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Data filed (Month, Dey, Year) 32. Registrar's Signetura

DHMH 16 Rev 6/95

State

Registrar

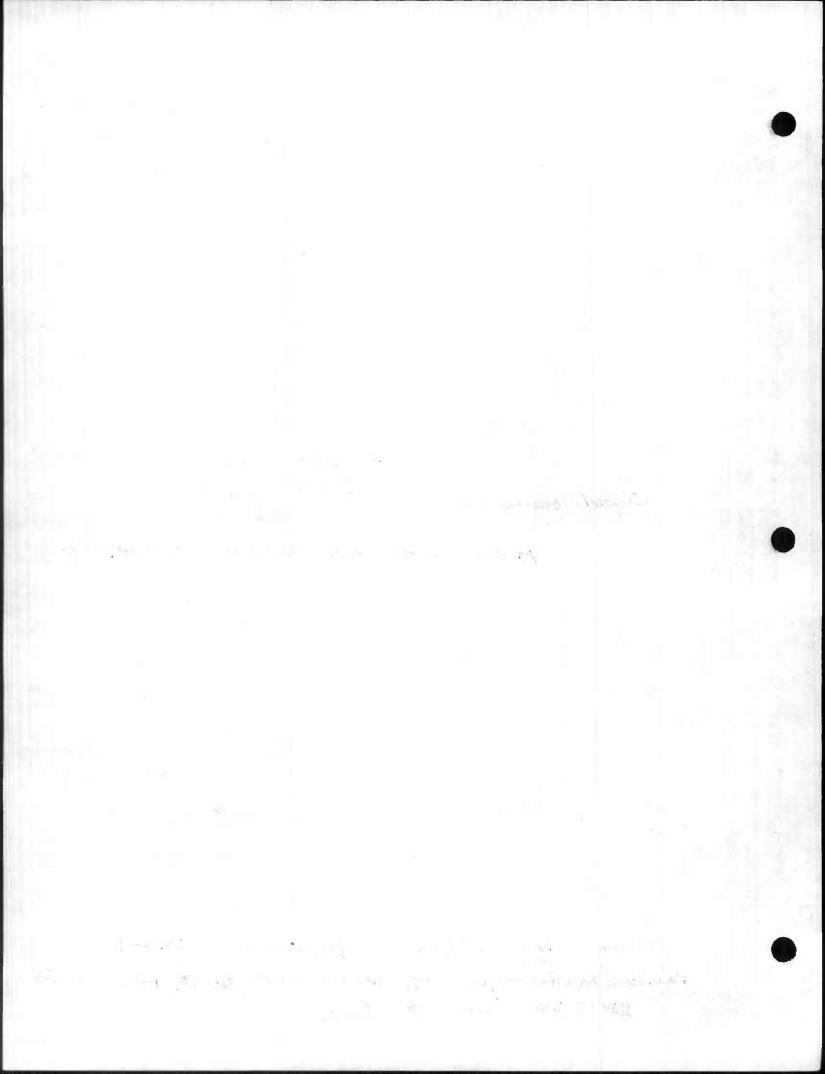
MAY 12



ysician				Certi	ificate of	Duani			Reg. No.	1	
ysıcıan	1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
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aminer	4e Fecility Neme (If not institution	-	ımber)			4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	
	6119 Moyer Ave	•				Balt		ce		n/	a
eral	5. Sociel Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. las		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Dete of Birt (Month, De	v. Year)	9. Birthp	placa (Stete or Foreign
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be notified a Director		/a				Balt	imor				XYes 2□No
Dir.	10e. Street and Number				10f. Zip Code				10g. Citizen of 1		
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Non must	11. Maritel Status	Armed Fo		13. Wa	as Decedent of I res, specify Cub	Hispanic Ori en, Mexican	gin? (Spi 1, Puerto	ecity Yes or No Rican, etc.)	- 14. Had	ck, White,	can Indian, etc.
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Be	17. Father's Name (First, Middle,	Last)	_					e (First, Middle,	Maiden Surnan	10)	
2	Pasquale		Piersant	:1		Mar	ia			(U	nknown)
700	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Stree	t end Numbe	er or Run	al Route Numbe	er, City or Town,	Stete, Zip	Code)
	Vincent S. Ali	mo / Step-			N. Char	les S	t.,	Baltimo	ore, MD	2120	01
	20e. Method of Disposition 1 □ Burial 2 💢 remation	2 Demousliferm		ce of Disposit	tion (Neme of tory or other ple	ice)		Date	20c. Location -	City or To	own, State
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8	21. Signature of Funeral Service	Licopena		22. N	Name and Addre	ess of Facilit	ly				1
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	23a. Part1. Enter the disease, of shock, or heart failure. List	complications that	caused the death.					44		ite, I	Approximete Interval Between
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rans	Sequentially list conditions,	b		as a conseque	ence of):					1	
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Registrar DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month 8:50 p.m. Ganesh Devii May 1, 1999 Patel 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Laurel Regional Hospital Prince George Laurel If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dala of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) 1 M 2 □ F Days Hours 64 Yrs. 212-29-6914 Jan. 10, India Usual Rasidenca of Decedant 10a Stata 10b. Counts 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 21411 Woodfield Road 20882 USA 14. Raca - Amarican Indien, 12. Wes Decedent Ever in U,S. Armed Forcas? Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status Black, Whita, alc 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dalas: 1 Nevar Married 2 Married Asian 1 ☐ Yas 2 X No Specify 3 Widowed 4 Divorcad Indian 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) 4 Technician Wood 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maidan Surnama) Devii Patel Mani Ben 19a. Informant's Nama/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town; Stata, Zip Coda) 21411 Woodfield Road, Gaithersburg, MD 20882 Kalpesh Patel/Son 20b. Pleca of Disposition (Nama of cematary, cramatory or other plece) Baltimore Washington Cr. 20c. Location - City or Town, Stata 20a. Melhod of Disposition Date 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 5/3/99 Laurel, Maryland 21. Signature of Funeral Sarvica Licanu 22. Name end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 The disaasa, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrest, went failure. List only one cause on each line. Approximeta Intervel Batween Onset and Death 10 RESPIRATORY ARREST (or es a consequence of): Immadiata Causa (Final disaasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last EED/NG Dua to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Examiner

Department of Important: If it eny injury or o

Physician

/Medical

Examiner

MD

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Director

Funerai

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Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haufin and Mental hygiens.
ant: If item 27 is marked other than "naturel", or frems 23s or 28e-f show uny, or other transmitter and the and the uny or other transmitter and the angle and the angle angle and the angle angle and the angle angle and the angle angle angle angle and the angle ang

Baltimore, Maryland 21215-0020

physician and the burial-transit Physician/Medical esn signed by the a by Completed Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics Be edicai Certification: To funeral

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

					24a. Was an autopsy periormad?	24b. Wara autopsy findings availabla prior to complation of cause of death?
25. Wes casa refarred to medical				26. Place of De	eath (Check only one)	,
axaminer? 1 ☐ Yas 2 No	Hospital: 1 Inpatiant 2	ER/Outpatient 3	□ DOA	Other: 4 Nursing		ar (Specify)
27. Mannar of Death 1 Natural 5 Pending 2 Accidant Invasligation		28b. Tima of Injury		Injury at Work? 1 Yas 2 No	28d. Dascribe how Injury occur	red
3 Sulcida 6 Could not be detarmined	28a. Place of Injury - At h building, atc. (Speci	ome, farm, straal, f	actory, of	fica	28f. Location (Street and Numb City or Town, Stata)	per or Rural Routa Number,
29a. Cartifiar (Check only one) 1 Certifying Ph. 2 Madical Example 1	yeician: To the best of my kno hiner: On the besis of examine and mannar stated.	owledge, daath occi elion end/or invastig	urred et II atlon, in	ha tima, data end plac my opinion, deeth occ	e, end dua to the cause(s) end me urred at the time, date and place,	enner es steted. and due to tha causa(s)

State Registrar

29b. Signeture end litle of cartifiar

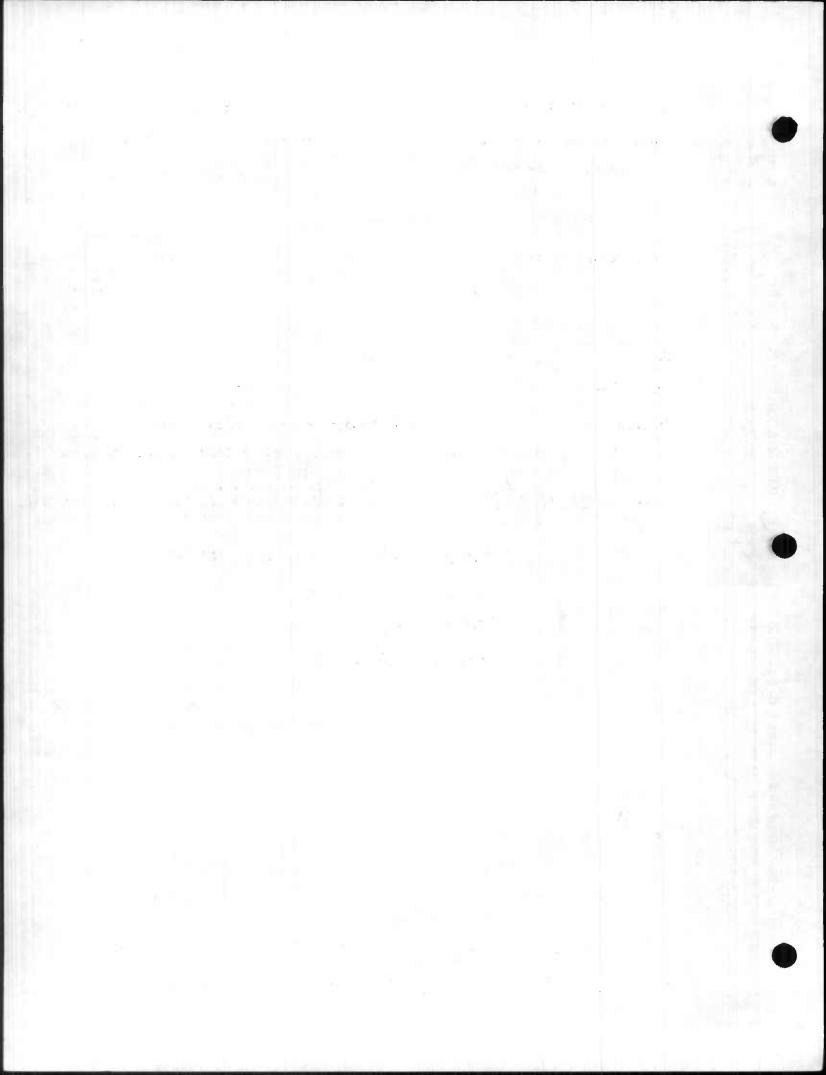
29c. License number 023242 29d. Data signad (Month, Day, Year)

30. Nama and address of person who complated causa of death (Item 23e) (Type, Print)

PKWay GREEN DELT MD

DHMH 16 Rev 6/95

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath Month Charles Yerkins 7:25 PM 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death 4c. County of Death Medical Center Baltimore n/a if Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) If Undar 1 Year 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months Deys 1**X** M 2□ F 83 Yrs. June 10 1915 Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥ Yas 2 □ No n/a Baltimore 10f. Zip Coda 10g. Citizan of What Country? 600 Light Street Apt. 821 21230 USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Marriad 1 Yas 2 No WWII IF Yas, Giva Yaar or Datas: 1□ Yas 2□ No Specify 3√ Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Store Keeper B & O Railroad 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charles H. Perkins Alice M. Woolmer 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Thomas (Daughter) 5618 Ballman Ave.Baltimore, Md. 21225 20b. Plece of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from Stata Cedar Hill Cemetery 5/12/99 Brooklyn Park, Md. 5 Othar (Specify) Funeral Sarvica Licensas 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Lung Carcinoma Dua to (or as a consequence of) Dua to (or es a consequance of): Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara autopsy findings availabla prior to complation of causa of death? 1 Tas 1 Yas 2 10

death with the Maryland 7 is marked other than "natural", or items 23s or 28s-f show traumstic svent, the Medical Examinar naint be notified at permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item any injury or other traumetic svent, its Medical Examina. Baltimore, Maryland 21215-0020 **Physician** /Medical

Physician

/Medical

Examiner

Funeral

Director

Mercy

5. Social Security Number

705-12-7283

10e. Street and Number

10a State

Md.

Director

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Completed

Be

2

Usuel Rasidance of Decedent

12

20a. Mathod of Disposition

4 Donation

Immediata Causa (Final

disaasa or condition rasulting in daath)

21. Signature of

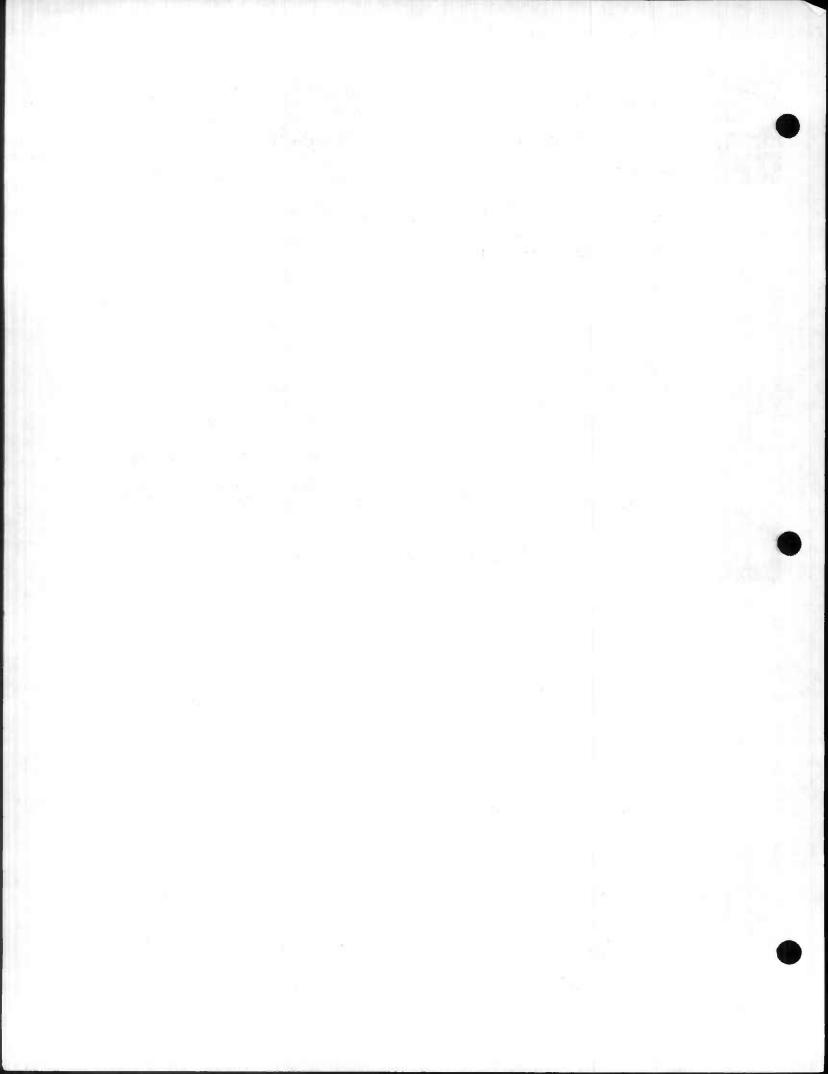
burial-transit and attending physician for use as the buria 88 The law requires that the death signed by the sid be detached peeu page 2 certificate has

Examiner Examiner Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifica Be 0 Medical Certification: filled in by the

Division of Vital Records, P.O. Box 68760.

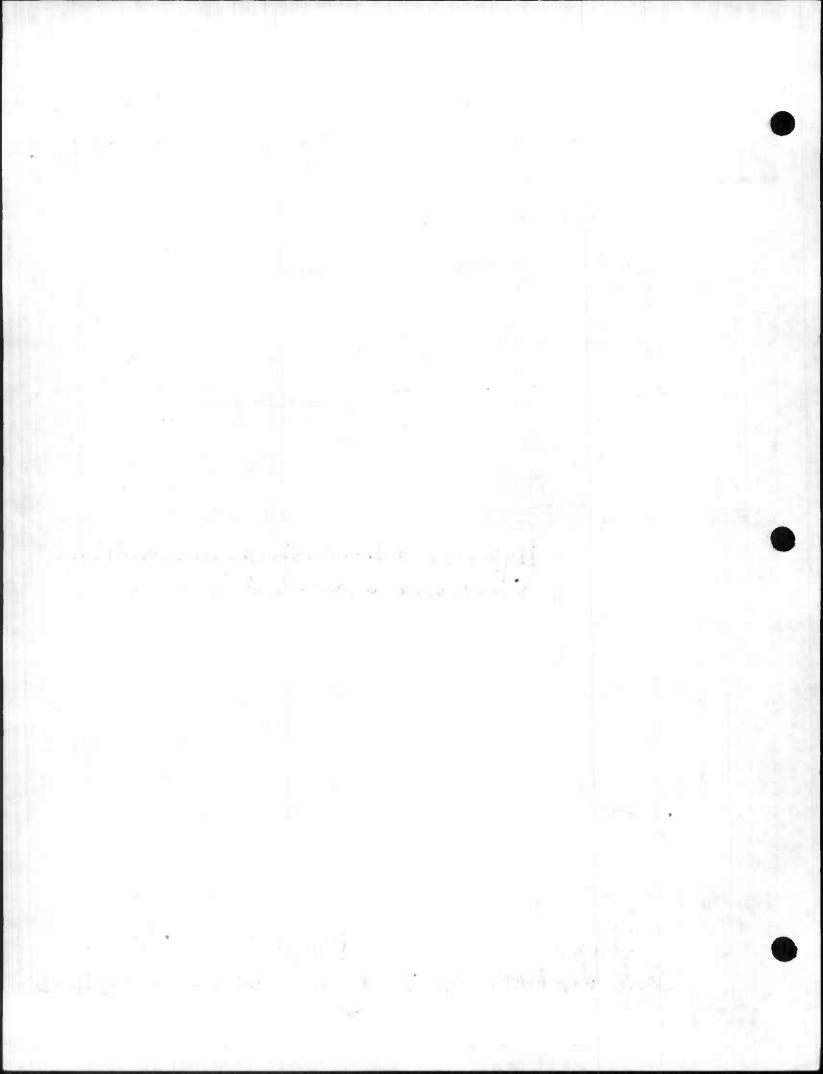
State Registrar

Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Diseasa or Injury that initiated avents rasulting in deeth) Last Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was cesa rafarred to madical axaminar? 26. Piece of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Pinpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Naturel 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcida 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicida 1 Certifying Physicien: To tha best of my knowladge, deeth occurred at tha time, dete end place, and due to tha ceuse(s) end menner as stated.
2 Madical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and placa, and due to the cause(s) and mannar stated. 29a. Certifia: (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name end addrass of erson who complated causa of deeth (Itam 23a) (Type, Print) 301 St. Paul Street, Baltimore, Md. 21201 0 32. Registrar's Signatura 31 Date filed (Magth: Day (Year)



State of Maryland / Department of Health and Mental Hygiene Q

				CUI	mouto	of D	C-C-11	He	eg. No.		
	1. Decedent's Name (First, Middle,	Last)						2. Date of Deat	ħ	V	3. Time of Death
nysician Medical	Spurgeon	R. Po	wers.	Jr.				Month	7, 19	Year 999	9:36P.M.
xaminer	4a Facility Name (If not institution,					4b.	City, Town, o	Location of Death	4c. County		
	Meridian North	Amindel				1	Slen Bu	rnie	Anne	a Aru	ındel
neral		3. Sex 7. A	ge (In yrs. la	st birthday)	If Under 1	Year	Under 24 Hr	s. 8. Date of Birth			lace (State or Foreign
ector	220-03-2439 Usual Residence of Decedent	18 M 2□ F	81	Yrs.	Months	Days	Hours Mir	June 13	3, 1917	Nort	h Carolina
rector	10a. State 10b. County		10c. City,	Town or Loc	cation					10	Dd. Inside City Limits
Funeral Director	Maryland Anne	Arundel	Pag	sadena							1 ☐ Yes 2 No
Directo	10e. Street and Number	711 CITACI	Lac	Jaca	10f. Zip C	Code		11	Og. Citizen of W	hat Count	trv?
0	274 Marchhu Dlasi					122			U.S.A		
ora	274 Magothy Blvd	12. Was Deceden	t Ever in U.S.	13 W	-		anic Origin? (Specify Yes or No-		- America	an Indian
Funeral	1 Never Married 2 Married	Armed Forces	?	If	Yes, specif	fy Cuban,	Mexican, Pue	Specify Yes or No- rto Rican, etc.)		k, White, e	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	□ Yes 2	№ No	Specify:		Specify:	Whi	to
	15. Decedent's	Education		16a. Deced	lent's Usual	Occupation	on ing most of w		16b. Kind of Bu		
Completed	(Specify only highest (Elementery/Secondary (0-12)	grade completed)		life. D	O NOT use	e retired)					THE PERSON
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Be C	17. Father's Name (First, Middle, La			- XA YA	110			ame (First, Middle, A			
O B	Spurgeon Ru	ıfus Po	wers,	Sr.			Lucy			Не	ester
	19a. Informant's Name/Relationship			-	g Address ((Street and		Rural Route Number,	City or Town.	State, Zip	Code)
	Doris Dukes (Da							adena, Mar			
	20a. Method of Disposition	agricor /	20b. Pla	ce of Dispos	sition (Name	e of			20c. Location - 0		
	1 Burial 2 Cremation 3		3	metery, crem							
	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic		GLe	en Hav	en Mei			5/11/99	Gien Bi	urnie	e, Maryland
	21. Signature of Fulleral Service Lic	0011500		M	icCull	y-Po.	lyniak	Funeral H	Home P.A	Α.	
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	Immediate Cause (Final	14.00	line.	0 04			7	ac or respiratory arre		0	Approximete Interval Between Onset and Death
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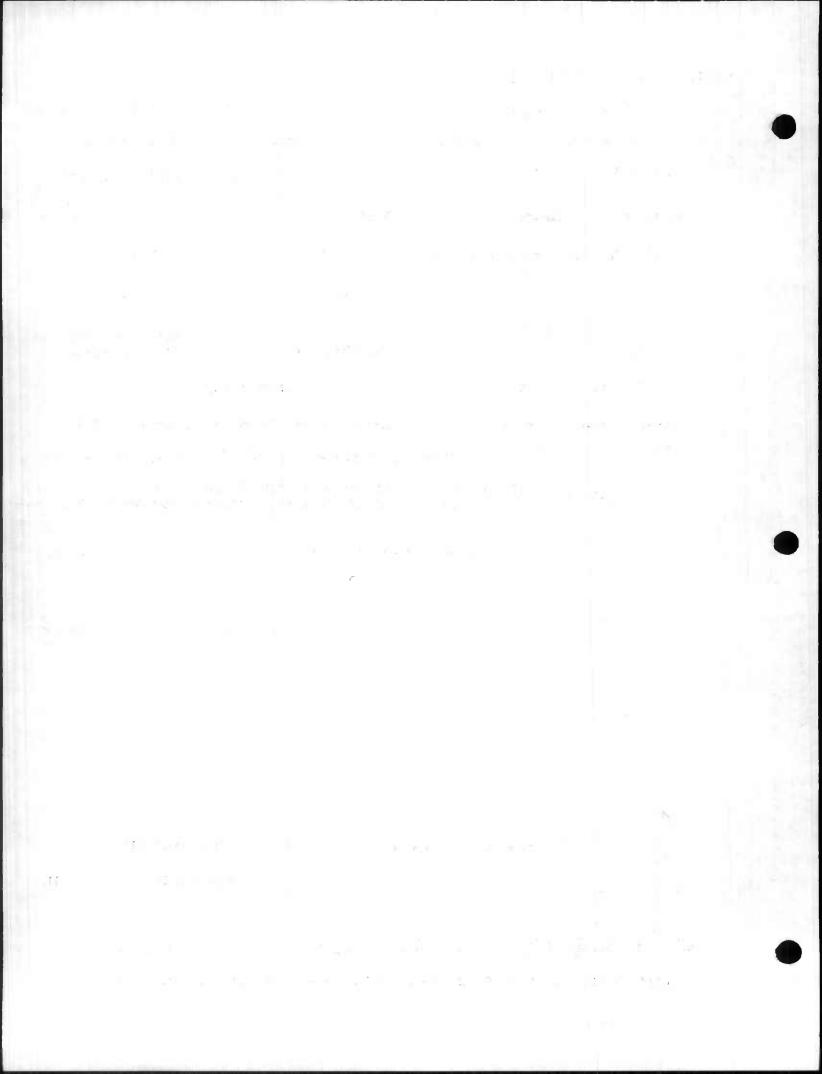


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Amended Items#28a-f perPhyG773/14/99 FW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** Month Yaer May 1999 Eric S. Peeples 7:35 am /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 4302 Bedrock Circle (Apt 303) White Marsh Baltimore Co Hours Min. 8. Date of Birth (Month, Dey, Year) If Undar 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthpleca (State or Foreign Country) **Funerai** Deys XXM 2 F Yrs. 220-96-3933 **Director** Jan 28, 1968 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore Co White Marsh Director Maryland 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 5 The Medical Examiner must be 4302 Bedrock Circle (Apt 303) items 23a 21236 U.S.A Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2200 lo If Yes, Give Yeer or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Reca - American Indian, Black, White, atc. 72 hours efter W Never Married 2 Married 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry filed within 7. Hygiene. other than "na Baltimore City Elementary/Secondery (0-12) College (1-4or 5+) Fire Fighter Fire Department h end Mental Hygie Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surname) eges 1 end 2 should be fill nit of Health end Mental H. I: If Itam 27 Is marked oth y or other traumatic even Gilbert W. Peeples Karen Reedy 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Karen L Hayes (Mother) 19 Eastford Court, Baltimore, Maryland 21234 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State Peges nent of h XXBurial 2 Cremetion 3 Removel from Stata permit. Pege Depertment of Important: If any injury or once. Grave Run Cemetery 5/12/99 Grave Run, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funeral Service Licansee 22. Nama and Addrass of Fecility Burgee-Henss-Seitz Funeral Home, Inc. an 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest shock, or heart feilure. List only one ceuse on each into Onsat and Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medicai Asphyia secondary to hanging 24 hours Examiner Due to (or es e consequence of): Examiner be executed end I-tran Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): physician e s the buriel-1 Box 68760, Physician/Medical Due to (or as e consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINE P.O. Pert II. Other algrificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t þ Records, 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 27, Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending Investigation death. 1 ☐ Yes 2 ☑ No Subject Hanged Self of or Attending of the formal 2 Accident Found 5-7-99 Unknown 3D\Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours of Funeral D etely filled i Home 4302 Bedrock Cir #303 Perry Hall, Md Hospital 29a, Certifier **Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. Medical To the Hosp within 24 hos To the Fune completely fi 29b. Signatu 29c. Licansa number 29d. Data signed (Month, Day, Yaar) D 18667 May 10, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Philip Militello, M.D. Shock Trauma, 22 S. Greene Street, Baltimore, Md 21201 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Sparks Registrar

MAY 1 2 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey O 7 Physician Robin Son Mae 125 PM /Medical Facility Name (If not institution, give street and number)

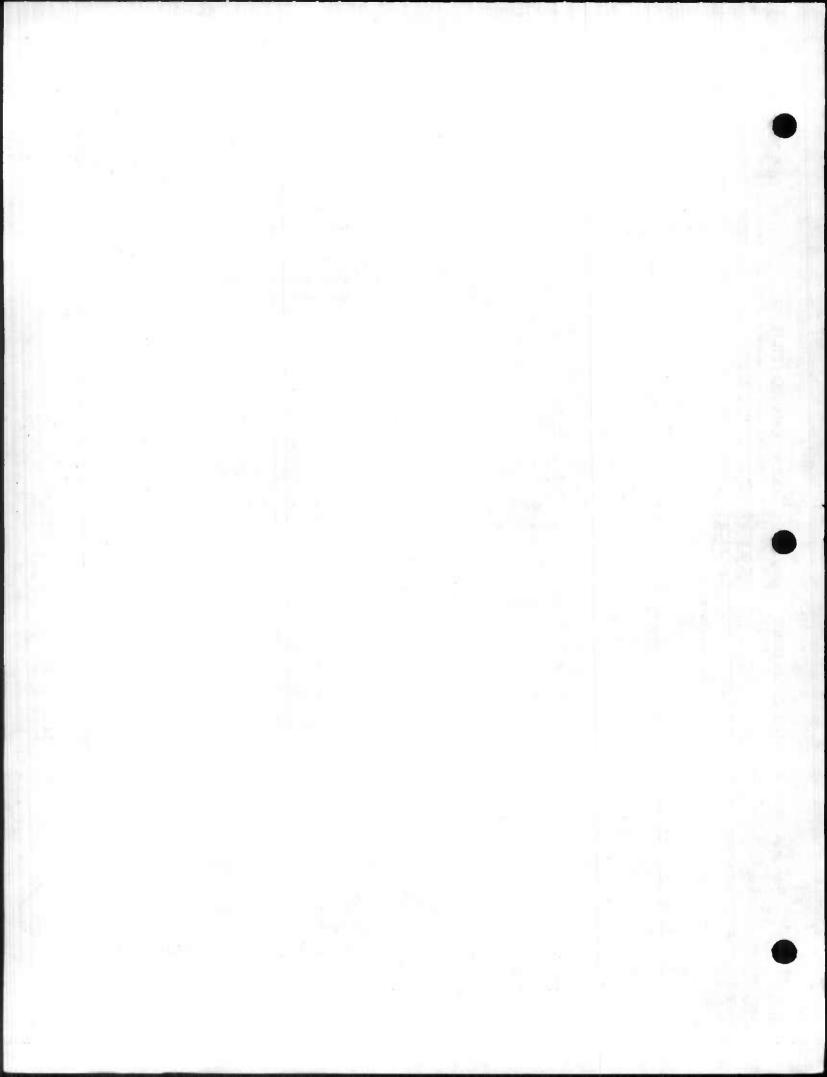
Inversity of Maryland 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore nospital iversit If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day MAR, 9 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Director the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Nama 23a or 23a-f show traumatic event, the Medical Examinar maist be notified at 12 Yes 2 No Director et and Nu 10f. Zip Code 10e. Stre 10g Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 O'No If Yes, Give Year or Dates: Funeral Race - American Indian, Black, White, etc. 11 Marital Status 72 hours efter 1 Newer Married 2 Married Black Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify ò 3 Widowed 4 Divorced Completed 160 Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filled within 72 Department of Health and Mental Hyglene. Importants if itsm 27 is marked other than "net, any Injury or other traumatic event, the Medical Stock. 15. Decedent's Education (Specify only highest grade completed) RIVAT College (1-4or 5+) ntary/Secondary (0-12) 17. Father's Name (First, Middle, Dest) 18. Mother's Name (First, Middle. Be AMES TORIE of Dispo 1 M Burial 2 Cremation 3 Permoval from State 4 ☐ Dopation 5 ☐ Other (Specify) re all Funeral Service Lig 21229 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode shock, or heart feiture. List only one cause on sech line. Approximate Intervel Between Onset end Deeth of dying, such es cardiac or n **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 24 hours Examiner Due to (or es e consequence of): Examine neumonia the buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): and Box 68760, physician Physician/Medical Due to (or es a consequence of). 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contributs to the causs of death? Division of Vital Records, P.O. 9 signed by t 1 ☐ Yss 2 ☐ No 3 Probably 4 ■ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an sutopsy performed? Completed peen s certificete hes 1 ☐ Yes 2 No 1 ☐ Yes 25. Wes case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ■ No Certification: To 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of tnjury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours effer death.
To the Funeral Director: Affer I 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only one) 29b. Signature and title of continue 29c. License number 29d. Date signed (Month, Day, Year) 24 07 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Maryland hospital Madhiraju Suhas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DH

DHMH 16 Rev 6/95

Registrar



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena.

Important: if lem 27 is marked other than "natural", or items 23s or 28s-f show any lojury or other traumatic event, the Modical Examiner must be notified at other.

Physician /Medical

Examiner

Be Completed by Funeral Director

10

Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

29b. Signature and title of certifier

Physician /Medical

Examiner

Funeral

Director

Pleas	se Type or Pri	int in Bia	ack Ir	ndeiible	e ink	c. Assu	re Al	II Copies	Are Le	aible.	
	State of M		/ Dep		nt of H	Health a	and M	Mental Hy	_	99	15633
1. Decedent's Name (First, Middle,	, Last)				117			2. Date of Dea	eath Dev	Vegr	3. Time of Death
J.G. Emil	Roeger							may	4.19	199	8:05 PM
4a Facility Neme (If not institution,	, give street and number	1)				4b. City, Tov	wn, or Lo	ocation of Death	1 4c. Cour	inty of Deat	ith
		HOSP Age (In yrs. lest i	, ,) If Under Months	r 1 Year Deys		24 Hrs. Min.	URNIE 8. Date of Birt (Month, Day	th Year)	Co	OUNTY hthplece (Stete or Foreign ountry)
192-22-7037	12 M 2□ F	94	Yrs.	Months	Dey	Hours	IVIII.	Feb. 24	4, 1905	5 Pen	nsylvania
Usuel Residence of Decedent		20.7									
10a. Stete 10b. County		10c. City, To	own or Le	ocation							10d. Inside City Limits
Maryland Anne	Arundel	G	len	Burnie	.e						1 ☐ Yes 2 No
10e. Street and Number				10f. Zip	Code				10g. Citizen o	of Whet Co	ountry?
455 Mainview C	it.				2106	61			Unite	ed St	ates
11. Maritel Stetus	12. Wes Deceden		13.	. Was Decer	dent of	Hispanic Ori	igin? (Spr	pecify Yes or No-			erican Indian,
1 Never Married 2 Marrie 3 XWidowed 4 Divorced	Armed Forces	s? XNo		If Yes, spec 1 ☐ Yes 2	cify Cub	ban, Mexicen,	n, Puerto I	Rican, etc.)	В	Bleck, White ecity: Wh	
15. Decedent's	's Education		6e. Decr	edent's Usue	el Occu	petion			16b. Kind of	f Business	-/Industry
(Specify only highest	t grade completed)		(Give	a kind of wor DO NOT us	rk done se retin	e during most	t of worki	ing			
Elementary/Secondary (0-12)	College (1-4or 5+			ometri					Self-E	Emplo	ved
17. Father's Name (First, Middle, L	1					18. Mothe	ar's Nami	ie (First, Middle,			4
Anton Roeger,							na Ma		Production of the Control of the Con	Service,	
			* 4 - 1						· T-	On to	
19a. Informant's Name/Reletionsh Jean M. Freeman			455	Mainv:	riew	ct. G	Glen	Burnie			Zip Code)
20e. Method of Disposition 1 Burial 2 X Cremetion 4 Donetion 5 Other (Sp.		te ceme	etery, cre	position (Name emetory or or Cremato	other pla	/	May 7				Town, State e, Maryland
21. Signature of Fundaral Service L	icensep				-			neral Ho E. Glen		a ME	21061
22a Part1 Enter the disease, or	complications that caus	and the death. [=,	Approximete
23a. Part1. Enter the disease, or o shock, or heart failure. List of the shock are conditions.	inly one ceuse on each	line.	101100	Aler the mod	9 UI Gy.	ing, such as	Caruro	or respiratory a.	1651,		Approximate Intervel Between Onset end Deeth
disease or condition resulting in death)	P	Due to (or es	s e conse	equence of):	//	LUR	100				
Sequentially list conditions,	b	Due to (or es	s e conse	equence of):	771	LUK					
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Cause (Disease or Injury that initieted events resulting in death) Last	C	Due to (or es	e conse	equence of):							
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Part II. Other significant condition				. ,		iven in Paπ I.					te to the cause of death?
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									s an autopsy ormed?		. Were autopsy findings aveileble prior to completion of ceuse of death?
								10	Yes 2000	1	1 ☐ Yes 2 1 No
25. Was case referred to medical examiner?							of Death	th (Check only o	one)		
1 Yes 2 No	Hospital: 1 Linpat	tient 2 ER/	VOutpatie	ent 3 DO	Of AC	hher: 4□ Nu	ursing Ho	ome 5 Resid	dence 6 🗆	Other (Spe	ecify)
27. Manner of Death 1 Neturel 5 Pending 2 Accident Investigation		jury Jay Year) 28t	3b. Time o Injury	of 2	28c. Inju Wo	uryat ork? □Yes 2□1		28d. Describe	how injury occ	curred	
3 Suicide 6 Could not determine	not be 28e. Place of Ir	Injury - At home, etc. (Specify)	, farm, s	treet, factor	y, office	3			(Street and Nu	ımber or A	Rural Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To State Registrar

mo

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

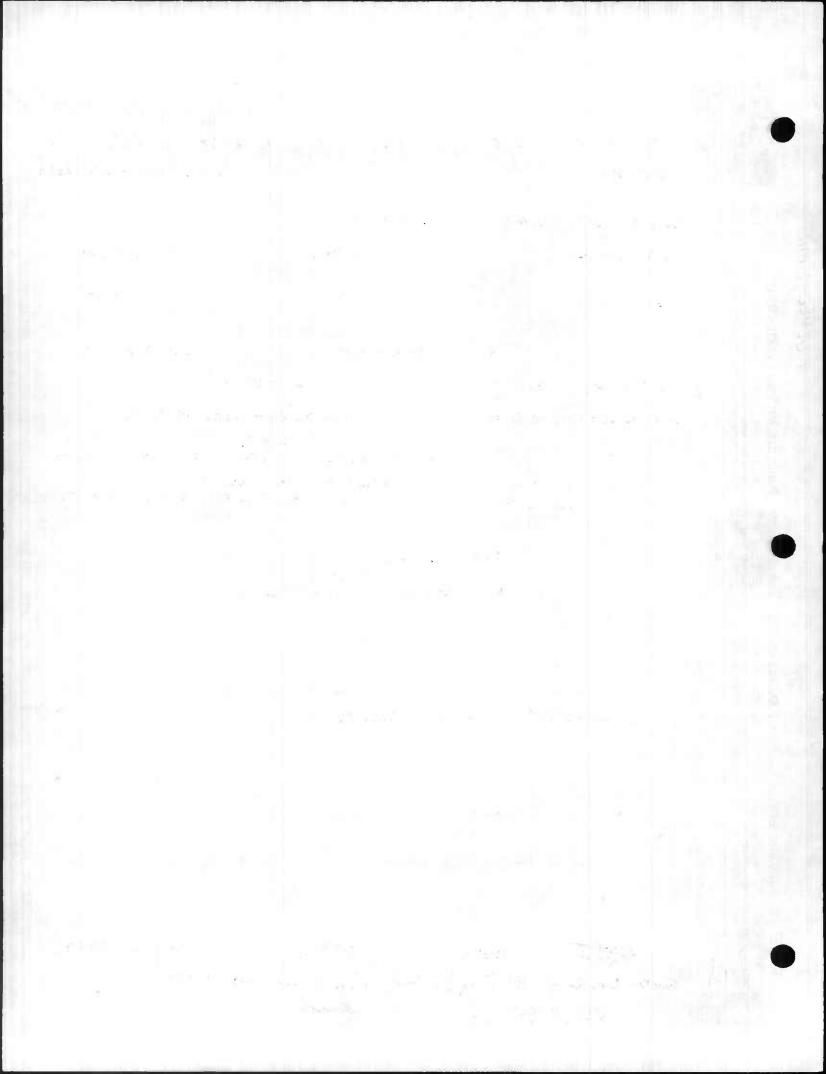
29c. License numbe

29d. Date signed (Month, Dey, Year) 999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

mie. mp. 2061 301 31. Dete filed (Month, Day, Year)

32. Regist MAY 1



	State of M	naiyiaii		rtificate of			Reg. No.	de	5634
	1. Decedant's Nama (First, Middle, Last)					2. Data of De	ath		3. Time of Death
n	ABRAM			ROTMAN		Manth	Day	1999	6:23 AM
al	4a Facility Nama (If not institution, giva street and number	r)	-	TO IT II II	4b. City. Town.	or Location of Death	4c. County		0 2014.
er	SINAL HOSPITAL OF	-	TMORE	e l		TMORE	N/A	0. 0000.	
		Aga (In yrs. I		T 44.44				0.0:44	alana (Chata au Fauria)
	213-41-5804 1MM 2DF	71	Yrs.	Months Days		lin. 8. Data of Bird (Month, Da	7,1927	9. Birth	place (Stata or Foreign ntry) RUSSIA
	Usual Rasidence of Decedant 10a. Steta 10b. County	10a Cin	. Town as I						
tor	MD BALTIMORE	10c, City	OWIN	GS MILLS					1 ☐ Yas 2 No
Funeral Director	10e. Street and Number 927 JOSHUA TREE COURT			10f. Zip Code	21117		10g. Citizen of V U.S.A.		ntry?
Jer	11, Marital Status 12. Wes Deceder	t Evar in U,	S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yas or No	- 14. Rac	e - Amari	can Indian,
DY FU	Armed Forces 1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced Yeer or Datas	No		If Yas, specify Cu 1 ☐ Yas 2 ☐XNo		erto Rican, atc.)	Specify	ck, Whita, /:	WHITE
8	15. Decedent's Education		16a. Dece	dent's Usuai Occu	pation		16b. Kind of B	usinass/In	dustry
ole	(Specify only highast grada completed)		(Giva	kind of work done DO NOT use retir	during most of a	working			
E	Elementery/Secondary (0-12) 4 College (1-4o	r 5+)	MANA				FACTOR	Y	
Be Completed	17. Fathar's Nama (First, Middle, Last)				18. Mother's h	Nama (First, Middle,			
To Be	(UNKNOWN)				10. 1410(1161 3 1		JNKNOWN)		
	19a. Informant's Name/Ralationship (Type, Print) ALEVTINA ROTMAN / WIFE			ing Address (Stree JOSHUA T		Rural Routa Number	er, City or Town, SS MILLS		
	20e. Method of Disposition			osition (Nama of		Data	20c. Location -	City or To	own, Stata
	1 Buriel 2 □ Cramation 3 □ Reprovel from Stet	0		matory or other pl		E /12 /00	OUTNICO	MITT	T.C. MD
	4 Donation 5 Other (Specify)	HAL		I CEMETE		5/12/99	OWINGS	MIL	LS, MD
	21. Signatura & Fungetti Service Uses (etc.)		2	2. Nama and Addi	ass of Facility	SOL LE	TVTNSON	& BR	OS., INC.
	1 aust		a	STAG UUG	TED STYNIAN	ROAD - H			MD 21208
	23a. Part Enter the diseesa, or complications that cause	ed tha death						125/	Approximata
	shown or haart failura. List only ona ceusa on aach	lina.							intarvel Between Onset and Death
									4
	immediate Cause (Final disaasa or condition	PSIS						1	2 WEEKS
	resulting in death)	Due to (or	as a conse	quence of):				1	
<u>2</u>	EN7	ERO	LITAN	LOUS	FISTU	LAE			2 WEEKS
Examiner	Sequentially list conditions,	Due to (or	as a conse	quence of):				1	
	Sequentially list conditions, if any, leeding to immadiate cause. Enter Undartying Causa (Disease or Injury	DOCO	0110	FISTL	1105				2 WEEKS
Ca	that initiated evants		as a consec		LATE			-	X WEEKS
8	rasulting in daath) Last			quarice ory.					0
\$	d. COL	0570	omy					1	3 WEEKS
3	Part ii. Other significant conditions contributing to death	but not rasu	ilting in the u	underlying cause g	iven in Part i.	23b. Did	lobacco une co	ntribute t	o the cause of death?
To be completed by Physician/Medic	CHRONIC OBSTRUCTIV	EH	ILMON	JARY D	SOASE	10	Yes 2 No	3 Pro	bably 4 Unknown
D.	0 11 1- 1/-	7				24a. Was	an autopsy	24b. W	ara autopsy findings
ě	CONGESTIVE ITEMET	TAIL	URE			perlo	rmed?	CC	railable prior to empletion of cause
Ē	0 =							of	death?
3	ATRIAL FIBRILLA	TION				10	ras 200 No	11	☐ Yes 2☐ No
9	25. Was casa rafarred to medical				26. Place of I	Deeth (Check only o	ne)		
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	27. Menner of Deeth 28a. Dete of in		28b. Tima o	of 28c. tnj	ıry at	28d. Describe	now injury occur	red	
9	Netural 5 Pending (Month, D	ay rear)	injury		Yes 2 No				
20	3 Suicide 6 Could not be 200 Biognati	niury - At ho	me farm st	reet, factory, office		28f. Location (Street and Num!	per or Run	al Routa Number,
La	4 Homicida determined 20a. Place of a building, a	tc. (Specify)			City or To	vn, Stata)		
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Medical Certification:	29a. Certifiar (Check only 2 Medical Examiner: On the basis	of axaminati	vledga, daat ion and/or in	h occurred at the livastigation, in my	ima, data and pla opinion, daath o	ace, and dua to tha courred at tha time.	cause(s) and mo data and place.	enner as s and dua t	stated. o the cause(s)
8	end mannar s	steted.							
2	29b. Signature and other of certifier			29c. Licer	se number		29d. Date signe	d (Month,	Day, Year)
	MULCIL	Maric	AL DOOR	ce D	12313		MAY	10.	1999
	30. Nama and address of person who completed cause of	death (item		Print)					
	JOHN ANDREW COOLEY,	2401	WES	ST BELVE	DERE AND	ENUE, BACT	MORE	MA	PYLAND
•	31. Deta filed (Month, Day, Year) 32. Regis	trar's signat	tre	4	10 11				
r	MAY 12 1999	Jens	,,,,,	N. 19	ours				

State Registrar

Physici /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or Nems 23a or 28a-4 show any Injury or other traumatic event, the Wedes Exercise must be notified at page.

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours effer death.

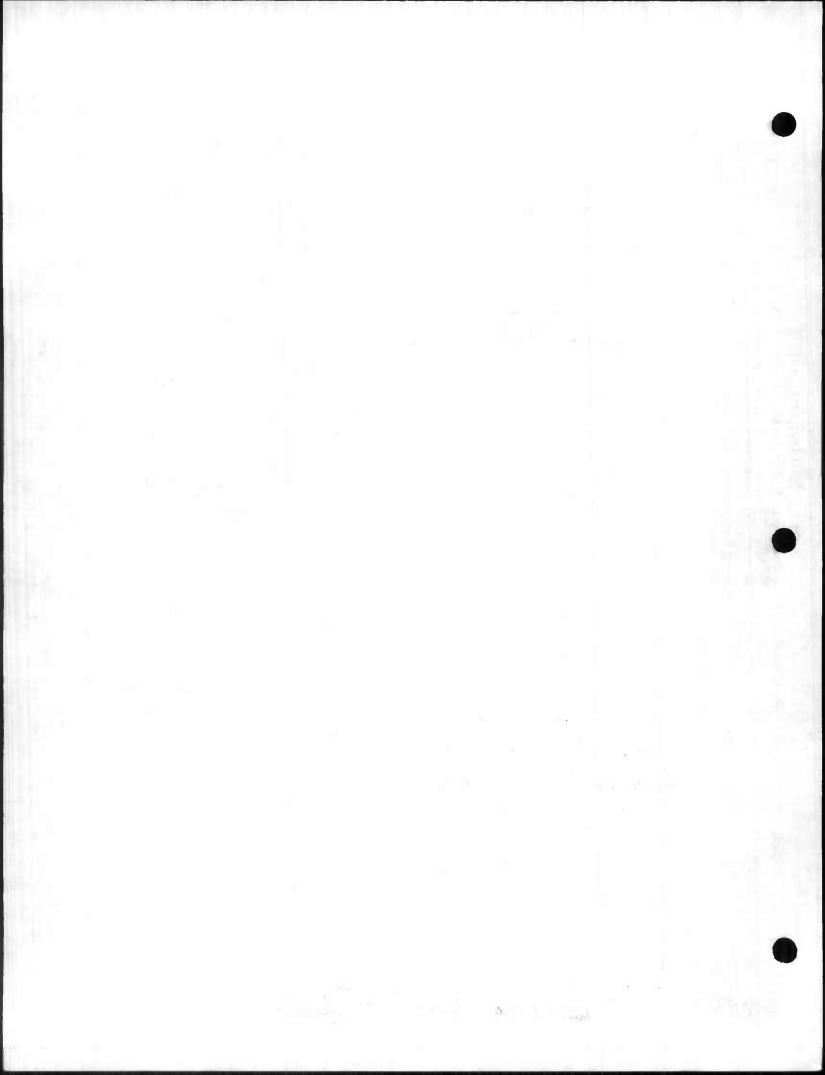
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Baitimore, Maryland 21215-0020

ROTMAN, ABRAM

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ARIE KODER 4:00 05 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death ALTIMORE BAYVIEW 40 PKINS JOHNS If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, 5. Social Security Number Birthplace (State or Foreign Country) 1 M 20 F Months Days Hours Min. 219-10-5404 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTO MID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 05 4 212 N. LAKEWOOD 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) It omE MAKER 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) WLADYSLAU 200 W1614 BDUSIEWICZ RUSZKOWSKI 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LAKEWOOD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State ROSARY 22. Name and Address of Facility KACZOROWSKI HOLY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ons that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, ause on each line. actorouse Approximate Interval Between Onset and Death Immediate Cause (Final ITRAL STENOSIS YEARS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

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ortant: if itam 27 is marked other than "netural", or items 23s or 28s-4 show injury or other traumstic svent, the Medical Examiner must be notified at

with the Marylend

death

Peges 1 and 2 should be filed within 72 hours efter

Department of Health end Mental Hygiene. Important: if item 27 is marked other than

Baltimore, Maryland 21215-0020

Examiner ician end bunal-trans physician Physician/Medical the 80 950

page 2

by Be Certification: To

Completed

requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the peed has After this certificate Hospital or Attending Physician: funeral director, after deeth. Director: Aft

24 hours a

To the To the

29a. Certifier

1 Natural 2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Dey Yeer) 5 Pending investigation

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier

HOUSE OFFICER

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN

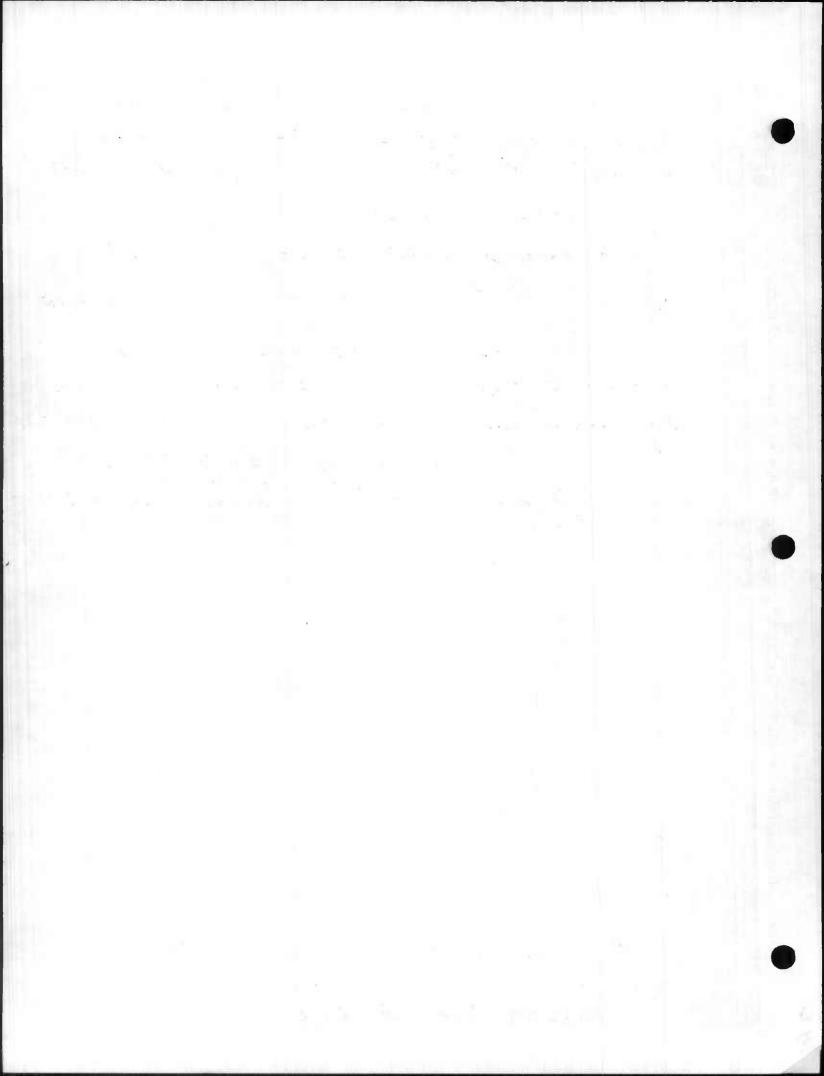
FRANCIS 5026A 600 NORTH WOLFE STREET JUHNS HUPKINS HUSBITAL, BALTIMINE, MD 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature

State Registrar

Medicai

1999





1. Decedent'a Name (First, Middle, Last)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Marylar

nd / Department of Health and I	Mental Hygiene		
Certificate of Death	Reg. No.	41	5636
	2. Date of Deeth	Venr	3. Time of De

Physici /Medic Examin

Funeral

Director

Pages 1 and 2 should be filled within 72 hours after

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death. To the Funeral Director: A

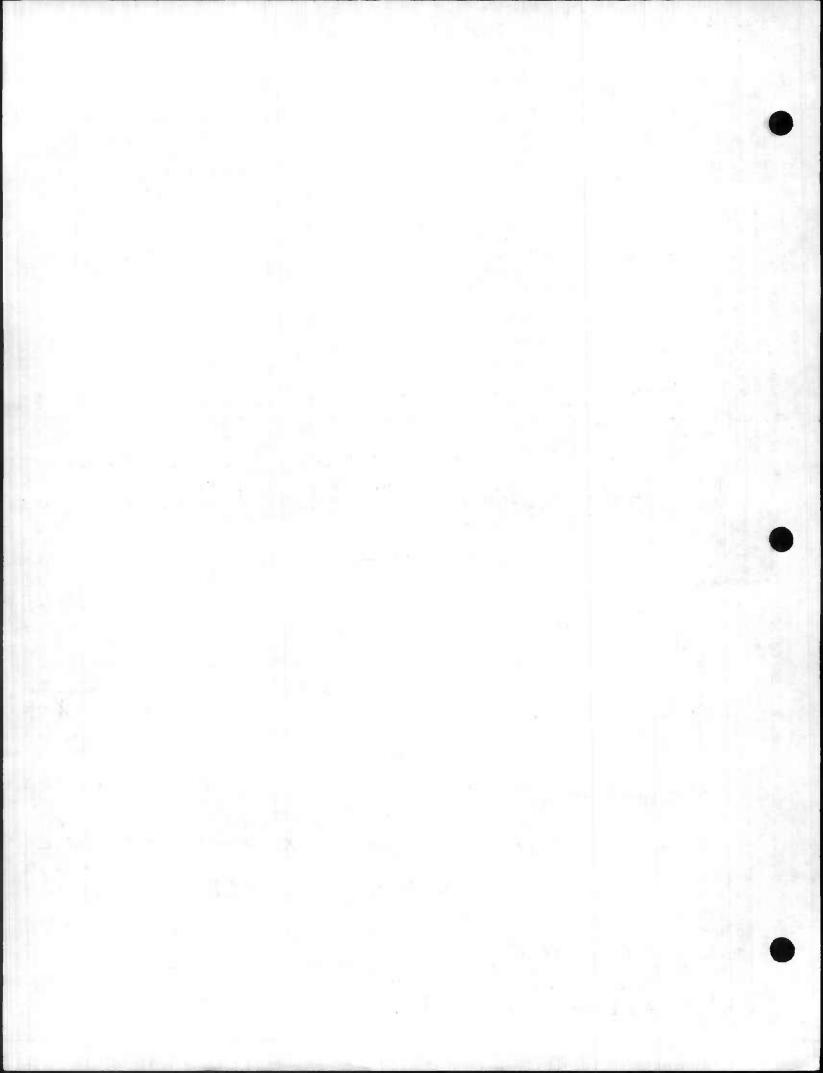
Division of Vital Records, P.O. Box 68760,

RICHARD P. ROI	LETTE						MAY 8	, 1999	Year	02	249 AM
4a Facility Name (If not institution	n, give street end n	number)			4b. City, Town,	, or Loca	ation of Death	4c. County	of Death		
UNIVERSITY H	OSPITAL S	S.T.U			BALTI	MORE	Ξ	N	/A		
5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days		Hrs. 8	B. Date of Birth (Month, Dey	Vear	9. Birthpl	ace (Si	tete or Forei
217-62-8207	1⊠M 2□F	44	Yrs.	World's Days	Hours			16,1955		YLA	
Usual Residence of Decedent							III KLLD	اددد		TUA	ND
10a. State 10b. County		10c. C	ity, Town or Lo	cation					10	d. fnsi	de City Limi
MADVIAND	T / A		DAT MITAGO	DE						10	Yes 2 N
MARYLAND 1 10e. Sfreel and Number	I/A		BALTIMO	101. Zip Code			1	Og. Citizen of V	Affron Cours	Pro-C	
				Tot. Zip Code				og. Citizen of v	WHAT COUNT	ry ?	
2026 WHISTLER	AVENUE			212	229			U.S.	Α.		
11. Marital Status	12. Was De Armed f	cedent Ever in U		Was Decedent of Yes, specify Cub	Hispanic Origin	? (Spec	ify Yes or No-		e · America		an,
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3 ☐ Widowed 4 ☐ Divorced	If Yes, C			ILIYOS 243 NO	Specify:			Specify	WHI	TE	
15. Deceden	t's Education		16a. Deced	lent's Usual Occu	pation			16b. Kind of Bu	siness/Ind	ustry	
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Elementery/Secondary (0-12)	College	(1-4or 5+)									
12			GR	OUNDS KE	1			NORTHRO		UMML	AN
17. Father's Name (First, Middle,	Last)				18. Mother's	Neme (First, Middle, I	Maiden Sumem	10)		
DONALD L. ROLI	ETTE, SR				DOR	RIS	A. FLET	CHER			
19e. Informant's Name/Relations	hlp (Type, Print)		19b. Mailin	g Address (Stree					Stete. Zio	Code)	
		1									01000
LINDA C. ROLLET	IE (WIFE	/		WHISTLER	AVENUE						21229
20a. Method of Disposition 1 □XBurial 2 □ Cremation	3 DRomovel from		cemetery, cren	sition (Name of netory or other pla	ice)	j	Dete	20c. Location -	City or To	wn, Sta	te .
4 Donation 5 Other (S			OTIDON D	ARK CEME	יתבטע	5/	12/00	BALTIMO	ODE :	MADI	VT AND
21. Signature of Funeral Service	Licensean 1	0		Name and Addr		10/	13/33	DALITIN	OILL.	LIMIN	LLAND
21. Signature of Full display	S V	//		BBARD FU		OME	TNC				
23a. Part1/Enter the disease, or	W. Kr	cervic	141	O7 WILKE	NS AVEN	IUE_	- BALTI	MORE, 1	MARYL	Approx	212
Sequentially list conditions,	b .——		or as a conseq						1		
if sny, leading to immediate cause. Enter Underlying											
Cause (Disease or Injury that initiated events resulting in death) Last	C	Due to (or as a consequ	uence of):					1		
resuming in usami) Last		,							1		
	d										
Pert II. Other significant condition	ns contributing to	death but nof res	sulting in the ur	nderlying cause gi	ven in Pert I.		23b. Did to	bacco usa co	ntributa to	the ca	use of deat
							1 🗆 Y	as 2 No	3 Prob	ably	4 Unkno
						_					(•
							24e. Wes a parform	n autopsy med?	cor	ailable p	opsy findings prior to n of cause
							H	ο Ω Δ1-	1.	1.	•Пан
							1 Y	es 2 No	'X	Yes	2 No
25. Was case reterred to medical examiner?						Death ((Check only on	Θ)			
YOYes 2□ No	Hospital:	Inpatient XX	ER/Outpatien	1 3 DOA	her: 4 \(\text{Nursir}	ng Home	e 5 🗆 Reside	enca 6 Oth	er (Specify)	
27. Manner of Death	28a. Dete	of Injury oth, Dey Year)	28b. Time of Injury	28c. Inju	iry at	28	d. Describe ho	ow injury occur	red Sa	bu	et.
1 □ Natural 5 □ Pendin	9 1.	155	0145 A		Yes 2 No	/	Leshoth	in stan	ch by	ve	Roll
3 ☐ Suicide 6 ☐ Could I	not be	a of fniury - At h		et, factory, office	/\	28	of, Location /S	reet and Numb	er or Rura	Route	Number
4 ☐ Homicide determ	buik	ding, etc. (Speci	fy)	Joi, ractory, Unice		20	City or Town	reet and Numb	co Plot	46	Shoupt
			order	w		1Sc	Weverd B	altimore	mary	ber	1
29a. Certifier 1 Certifyin (Check only one)	g Physician: To th Examiner: On the i and ma	e best of my kno basis of examine nner stated.	owledge, death stion and/or inv	occurred at the trestigation, in my	me, date and plopinion, death o	lace, an	d due to the ca d et the time, d	ause(s) end me ate and placa,	enner as st and due to	aled. the car	use(s)
29b. Signature and fitle of cartified				29c. Licen	se number		2	9d. Date signer	d (Month, L	Day, Ye	er)
1	1141			0.0	C.M.E			MAY 9			
leel	H. Kes	200									
30. Name and address of parson	who completed cay	of death (fter	m 23a) (Type, I	Print)							

State Registrar

DHMH 16 Rav 6/95

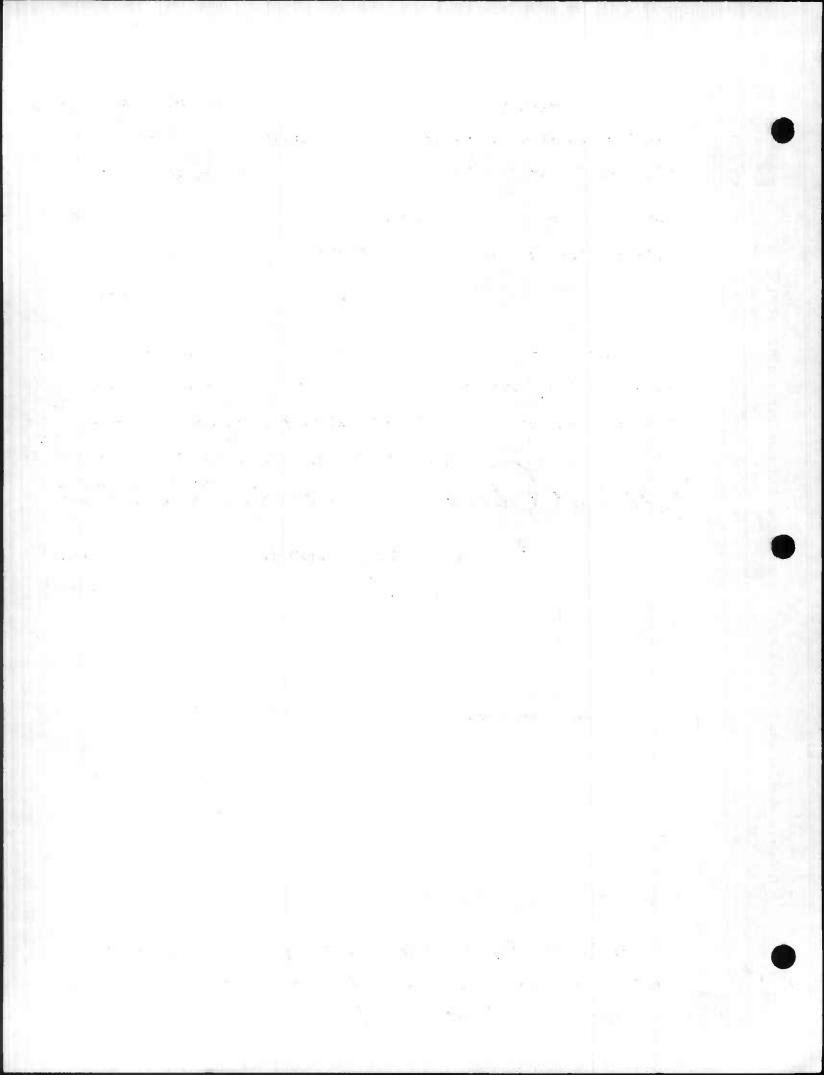
111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month May 0^{Dey}, **Physician** 99 12:15AM Simmons Asa /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 1513 North Ellwood Avenue Baltimore If Under 1 Year 5 Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Devs Hours 78 Yrs. 228-18-9622 Director 06-26-20 NC Usuel Residence of Decedent the Manyland 10d. Inside City Limits 10a State 10h County 10c City Town or Location 7 is marked other than "nature!", or items 23a or 28a-f show trsumstic svent, the Wedical Examiner must be notified at YYes 2 No Baltimore Director MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 1513 N. Ellwood Avenue death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Bleck, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after arment of Health and Mental hygiene. ortant: if item 27 is marked other than "natural", or item injury or other traumatic syent, its Medical Exercise. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 20 Merried Saltimore, Maryland 21215-0020 1 Yes 28 No Specify Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16b, Kind of Business/Industry 16e. Decedent's Usuel Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 9th Grade Pipe Fitter Contential Can Co. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Manley Willie Vannie Allen Simmons Mae 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 3 19e. Informent's Neme/Reletionship (Type, Print) 1513 N. Ellwood Avenue Baltimore, Maryland Louise Simmons 20c. Location - City or Town, Stete MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete 4 Donetlon 5 Other (Specify) permit. Page Department of Important: If any injury or Cem. 05+12-99 Owings Mills, Garrison Forest VA 22. Name end Address of Fecility re of Funeral Service License Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Finel disease or condition resulting in deeth) 3 MONTYS Examiner Due to (or es e consequence of): Examiner 3 MONS41 Preumonia requires that the death certificate be executed physician and the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieled events resulting in deeth) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical eut Due to (or es e consequence of): usa as i Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown CANCER signed b P 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peen paga 2 has 1 Yes 2 □ No 1 NYes 2 No cartificata • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this carific funaral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) Certification: 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Naturel 5 Pending 1 TYes Investigation 2 Accident 3 Sulcide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated. edical 29e. Certifier complately To the To the To the 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number nual 30. Name and eddress of person who completed cause of deeth (tem 23e) (Type, Print) PURTEll MILMARL ISA LTIMURE 4940 TEASTELV 31. Dete tiled (Month, Day, Year) 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea **Physician** MAY 09 1999 3:15 AM KATHERINE A. /Medical 4e Fecility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** N/ABALTIMORE 2116 SIDNEY AVE. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1□M 20XF Yrs. 62 212-34-7567 Director July 31, 1936 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Illed within 72 hours aher death with the Maryla Hygieth Hydrach other than "setural", or Herne 23e or 28e-f shoo ent, the Medical Examiner must be notified at 1X Yes 2 No Director Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2116 Sidney Avenue 21230 Funeral U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Giva Yeer or Detes: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 9th 0 Glass Packer Glass Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be III.
Department of Health and Mental H
Important. If them 27 is marked other
any injury or other traumetic even Be Edgar Hynes Windna Seymore 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Jerome (Daughter) 2309 Sidney Avenue Baltimore, Maryland 21230 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Green Mount Crematory 5/12/99 Baltimore, Maryland 21. Signeture of Funerel Service Licenses McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Physician Immediata Cause (Finel disaase or condition resulting in deeth) /Medical Examiner raum attending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of) Physiclan/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 5 3 Probably 4 Unknown 1 Yes 2 No signed b Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed 20 No 1 Yes 2 No 1 Yes certificate Division of Vital or Attending Physician: after deeth. Director: After this certifica Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Notural 5 Pending 1 Yes 2 No 2 Accident Investigation n 24 hours after der he Funeral Directo pletely filled in by the 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital Medical 29a. Certifier 🛱 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and menner stated. 29b. Signeture and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0000563 MD 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

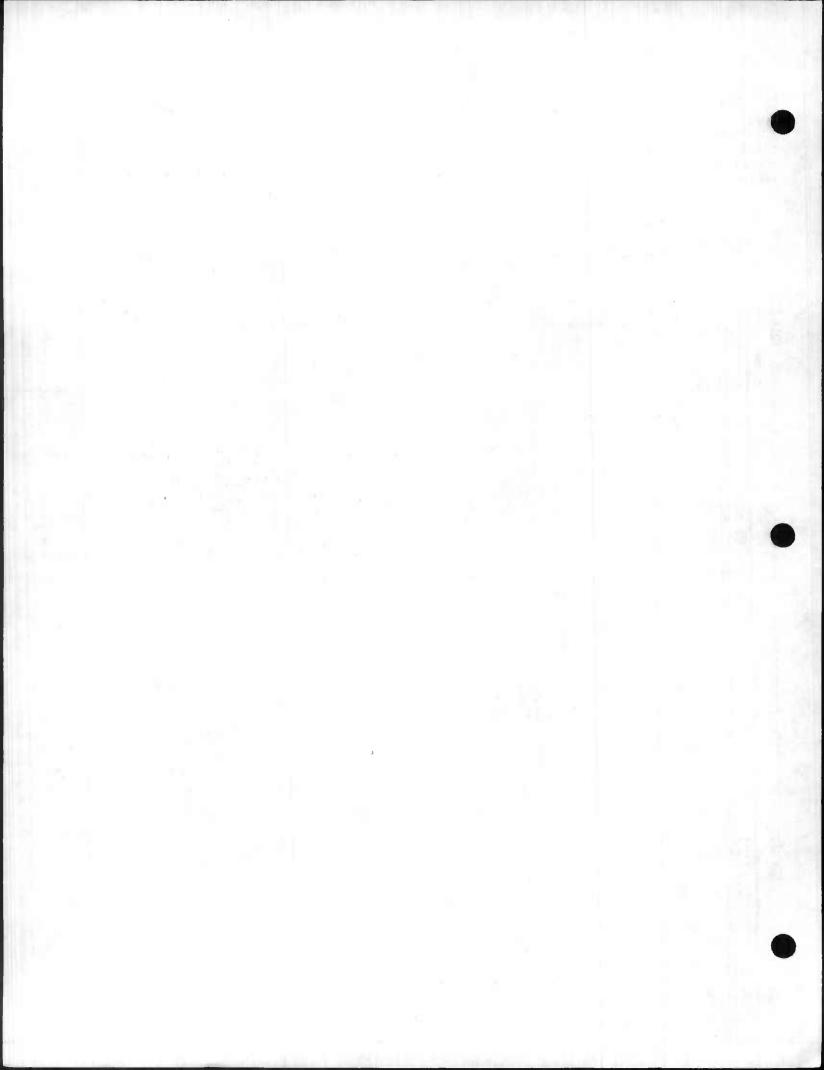
Registrar **DHMH 16 Rev 6/95**

State

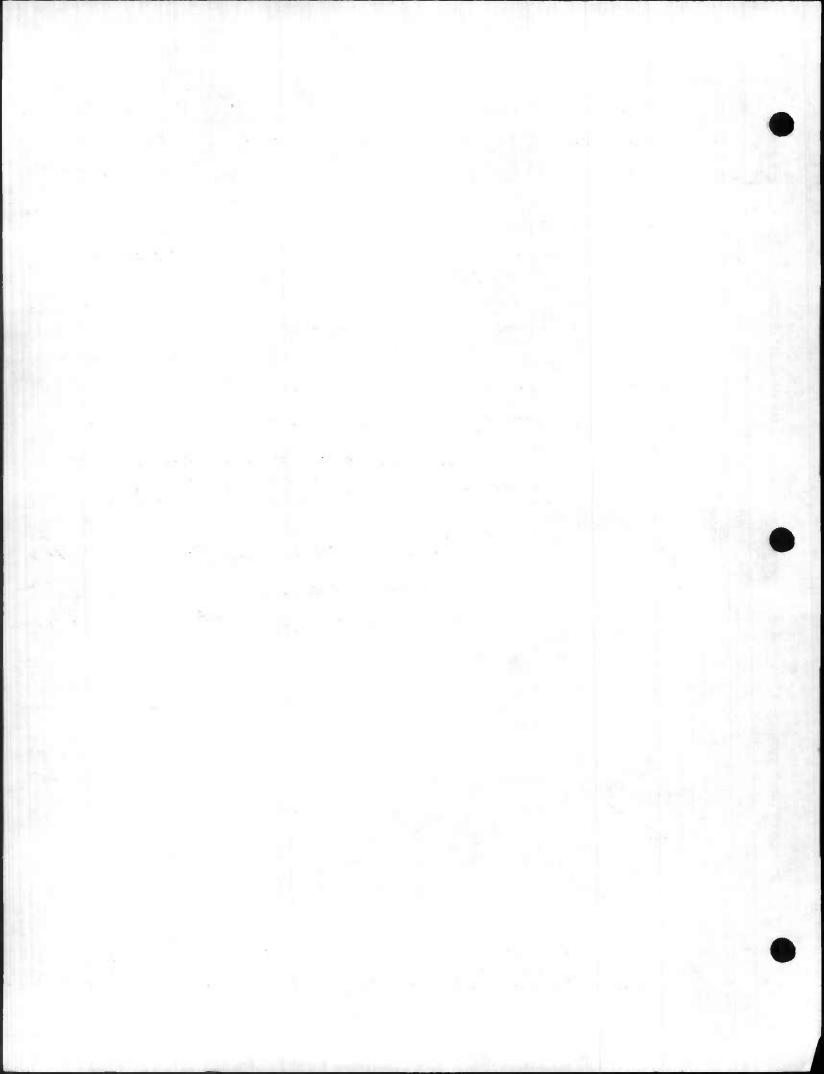
31. Date filed (Month, Day, Year) MAY 1 3 1999

Dr. Roubein JiJi 3001 South Hanover Street Baltimore, Maryland 21230 32. Registrer's Signature

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Year Month **Physician** 1999 Thelma Atlas Spoone May 3:00 A.M. 11, /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Yrs. Director 225-03-2866 Jan. 20, 1914 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 X No Director Anne Arundel Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 308 Townsend Avenue 21225 U.S.A. Funeral 12 Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) t 4. Race - Amarican Indian, Black, Whita, etc. 72 hours after 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 21215-0020 1 Yes 2/ No Specify: P 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ** pay Injury or other traumatic event, the Macando. Elementery/Secondary (0-12) College (1-4or 5+) 12th 0 Seamstress Sparkle Cleaners Baltimore, Maryland 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Peter Ingles Sanders Sarah Melvina Ketron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Cutsail (Daughter 308 Townsend Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 X Burial 2 Cremation 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 5/13/99 Glen Burnie, Maryland 21\Signature of Funeral-Bervice Licensee McCully-Polyniak Funeral Home PA. Kevin E. Ecker 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heer failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** Termina cavenous Bost Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last that the death certificate be execu Box 68760 Physician/Medical Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1□Yes 2ENo 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 10 shis 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury at Work? edical Certification: After 1 Netural 5 Pending investigation a Funeral Director: Afti Pletely filled in by the fun 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) end menner steted. 29c. License number 29b. Signature end title of certifier 29d. Data signed (Month, Dey, Year) S. Museper M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 POTER STREET BALTIMORE MD 21225 MUNESES MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar Sparker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death MAY 08 1999 5:08 PM MARGUERITE R. SPRINGER 4b. City, Town, or Location of Deeth 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth HOWARDCOUNTY ELLICOTT CITY ST. AGNES NURSING HOME 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□ M 2√2 F Days Hours 75 Yrs. 217-12-8304 Jan. 30 1924 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 143 E. Randall Street 21230 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Officer Worker Shoffer Furniture 17, Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Philip Oler Doris Will 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) William A. Springer (Husband) 143 E. Randall Street, Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 5/12/99 Glen Burnie, Md. 21. Signature Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximately 130 E. Fort Ave., Baltimore, Md. 21230 Approximatel Approximete Intervat Between Onset and Death Immediete Ceuse (Final Aspiration disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementa 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Was en eutopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Be Completed

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Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exampler near be notified at

Director

by

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the Maryland

72 hours after

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pernit. Pages 1 and 2 should be filed withir Department of Health end Mental Hygiene. Important: If itsm 27 Is marked other than any injury or other traumatic event, II a Manay injury or other traumatic event, II a Manay injury or other traumatic event, II a Manay injury or other traumatic event, II a Manay injury or other traumatic event, II a Manay injury or other traumatic event, II a Manay injury or other traumatic event, II a Manay injury or other traumatic event.

Baltimore, Maryland 21215-0020

buriel-transit end physician s the burie certificate

P.O. Box 68760 Records, Division of Vital After this Hospital or Attending PI
 24 hours efter death.
 Funeral Director: After the letely filled in by the funeral To the Hospitar — within 24 hours effer To the Funeral Dir

Registrar

1 Naturel

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homlcide

29b. Signature end little of certifier

5 Pending Investigation

6 Could not be determined

caresm

Center Orice Ellicott City

1) 32. Ragistrer's Signature

Annul

, MO

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D-0053636

Cartifying Phyelcian: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and menner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated.

29c. License number

1 Tyes 2 No

May 11, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MD 21043; KEVIN BISHOFF CAPLSON AS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:27 AM Mar /Medical 4b. City, Town, pr Location of De 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner more Mary Sa MIVERSI n/a If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 XM 2□ F Months Deys Hours Min. 79 Yrs. **Director** March 29 1920 Virginia 219-01-4409 Usuel Residence of Decedent the Maryland show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at Yes 2□No Director Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 600 Light Street Apt. #929 21230 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or ferma 23a eary injury or other traumatic event, the Medical Examples. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, GiveX Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: white þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Martin Marietta 12 Supervisor 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Jacob Starkey Iuna Sewell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 600 Light Street Apt. 929, Baltimore, Md. 21230 Dorothy A. Starkey (Wife) 20b. Placa of Disposition (Name of cametery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 5/10/99 Baltimore, Md. GreenMount Cemetery Other (Specify) 4 Donation 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the bunal-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or as a consequenca of): use as 1 the > Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen has 1 ☐ Yes 20 No 1 Yes 2 ₩o i or Attending Physician: after death. Director: After this cartific funeral director, 25. Was case referred to medical exeminer?
1 □ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 PER/Outpatient 3□ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier (Check only one) TECartifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medicai completaly To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tille of cartifier 29c. License number 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Reduced St. Snite 280 mis Eneme 419 W

32. Registrer's Signature

State Registrar

BOTTO OF ACCUSED A PERSON OF THE STATE OF TH No. 175.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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xaminer	4a	Facility Name (If not institution, give	e street and num	ber)			4b. City, Town	, or Location of Dee	Ih 4c. County	of Death	
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neral ector		Social Security N 15-09-08		ex M 20 F	7. Age (In yrs. 89	. last birthday) Yrs.	If Under 1 Ye Months Day		Hrs. 8. Date of Bi Min. (Month, D MAR 2	orth ay, Year) 5, 1910	9 Birthp Coun MAF	place (State or intry) RYLAND
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notified at		MD	N/A			BALTIMO						1 XYes 2
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death HEURY Month 1 YSON 4a Fecility Name (ff not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BonSecour Hospital Baltimore NA 7. Age (fn yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 06-30-16 Birthpiece (State or Foreign Country) NC 5. Social Security Number Days 1 M 2 □ F 82 Yrs 245-22-5003 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits X Yes 2 No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2042 Preston Street 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/2/10 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) various trades 3rd. Grade Laborer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Hattie Pearl Tyson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21213 19a. Informent's Name/Relationship (Type, Print) 2042 E. Preston Street Baltimore, MD. Carlean Campbell 20b. Piaca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Voshell Mem. Gardens 05-14-99 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the disease, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death the mode of dylng, such es cardiec or respiretory errest, Asbiration Immediate Ceuse (Finel diseese or condition resulting in death) as e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Parj i. 23b. Did tobacco usa contributa to the causa of death? 3 Probably 4 Unknown 1 Yes 2 No 0 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 2 2 No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Unpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28h. Time of

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/Medical

Examiner

Director

Funeral

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?) is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

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Physician

/Medical **Examiner**

Physician/Medical Examiner

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Completed

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Certification:

Medical

29a. Certifier

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? 1 Yes 2 Vo

27. Manner of Death 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 5 Pending investigation 1 Naturel 2 Accident 1 ☐ Yes 2 ☐ No

6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner es stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of cartifier lacem 29c. License number 29d. Date signed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

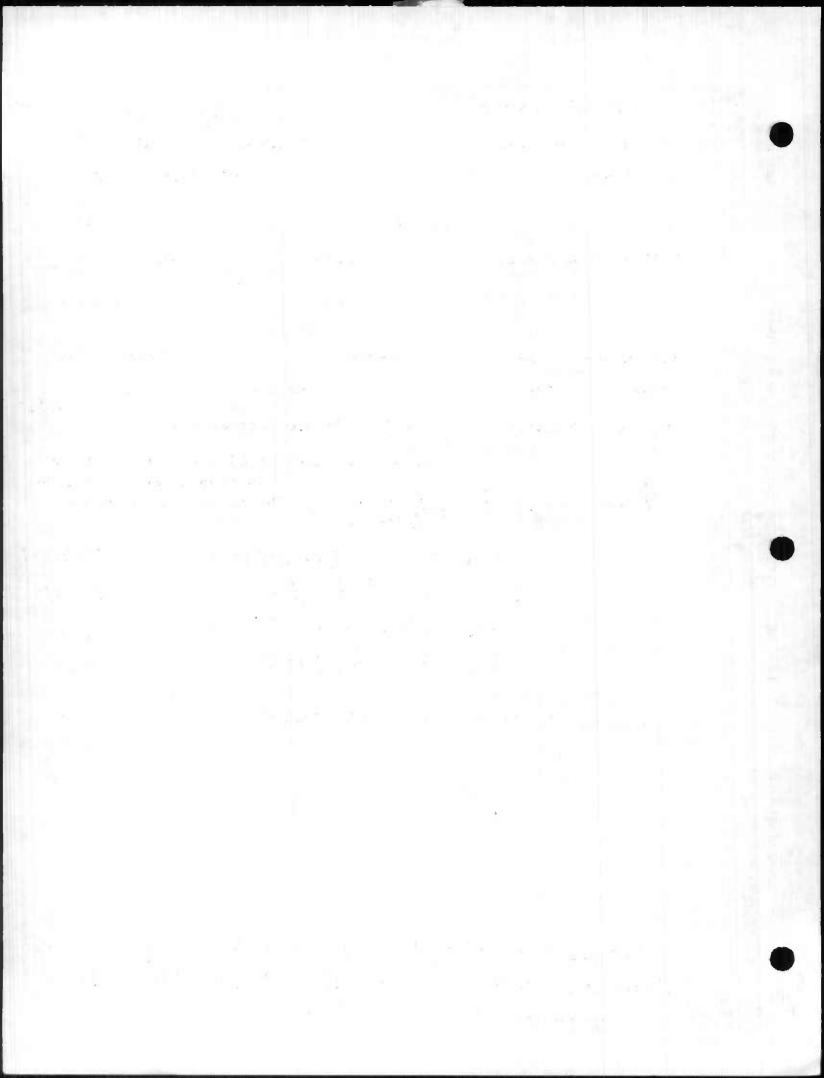
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State Registrar 31. Date filed (Month, Dey, Year)

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jacqueline Rita Thompson 1999 MAS 12:50 PM. 0 /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Rosedale
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, SQUARE 0 6. Sex BAITIMORE Hospila ConTen 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2□F Months Days 219-80-2894 October 9,1959 Chesapeake Beach, MD Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor trsumatic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6614 Blackhead Road 21220 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispento Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indien 11. Maritel Status Bteck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Food Preparer Horn & Horn is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Howard Andrew Thompson Janet Rita Draver JACQUELINE 19a. Informant's Name/Retationship (Type, Print) 19b. Malting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Howard A. Thompson (Father) Depertment of Health Important: If Item 27 6614 Blackhead Road Baltimore, Maryalnd 21220 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory Inc. May 13, 1999 Baltimore, Maryland 22. Name end Address of Facility 21. Signetyre of Funeral Service Licensee Lassahn Funeral Home, Inc. prock 7401 Belair Road Baltimore, Maryland 21236-4625 23a. Part 1. Enter the disease, or complications the dused the death. Do not enter the mode of dying, such as cerdiac or respiratory eighted, or heart failure. List only one cause on each line. Approximate Intervet Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical e. BronchopneumoniAfflettupper lobe
Due to (or as a consequence of): Examiner Re Diffuse Pulmonary Fibrosis
Due to (or as e consequence of): Examiner end Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that hittaled events resulting in death) Last physicien certificete be Physician/Medical the Due to (or es e consequence of) signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20 No 3 Probably 4 Unknown 1 Yas Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Was an autopsy performed? 1 Yas 2 No 1 Yes 25. Was cese referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Investigation 1 Natural ne Hospital or Attending in 24 hours efter death. he Funeral Director: Afte 1 Yes 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the To the To the I 29c. License number 29d. Dete signed (Month, Dev. Year) 29b. Signature end title of certifie 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 9000 FRANKIIN 5 gua RE DRIVE Shinners BATTIMORE, MARYLAND anvel.

32. Aegistrar's Signature

State Registrar

31. Dete filed (Month, Day, Year)

MAY 12 1999

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Day H Month **Physician** 4:40Am TELLA THOMAS. MAY 08 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Name (If not institution, give street and number) Examiner BALTIMORE CENTER RANDALLSTOWN NORTHWEST GOSPITAL If Under 1 Year 8. Date of Birth (Month, Day, Year) July 15, 1915 Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) If Under 24 Hrs. 5. Social Security Number **Funeral** 1□M 2K)F Days Months Hours Min Maryland Yrs. 215-03-2310 83 Director Usual Residence of Decedent the Meryland 10c. City, Town or Location 10d. fnside City Limits r 28a-f show 10a State 10h County Yes 2 No Director Md. N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with t and of Heelih and Mentel hyglene.
Int. If item 27 Is marked other than "naturel", or items 23s or 2 and yor other traumatic event, I'm Magical Example marke 3534 Fourth Street 21225 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8th 0 Clerk Convenience Store 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) (Unknown) Unknown 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Phillip Thomas (Son 2303 Forest Hill Road Marriottsville, Md. 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or o 1 X Buriel 2 Cremetion 3 Removal from State Holy Cross Cemetery
22. Name and Address of Fecility 4 ☐ Donetion 5 ☐ Other (Specify) 5/12/99 Baltimore, Maryland 21. Signature of Funeral Service Licenses Kevin E. Ecker McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate Physician /Medical Immediate Ceuse (Finel · AINOMUSING. disease or conditio resulting in death) Examiner Due to (or as e consequence of) Examiner physician end the burief-transit certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of) signed by the e Pertiff. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Partif. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HIPERTENSION P 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en autopsy Completed CONGESTIVE BEART FAILURE. certificete hes b lirector, pege 2 s 1 ☐ Yes 2 No 1 Yes or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 this funeral 28a. Dele of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident efter deeth Director: n 24 hours efter dee se Funeral Director pletely filled in by th 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated THYSICIAN 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier HOUSE D 42723 MAY

State Registrar 31. Date filed (Month, Day, Yeer) MAY 1 3 1999

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print),

HORISH 32. Registrer's Signature

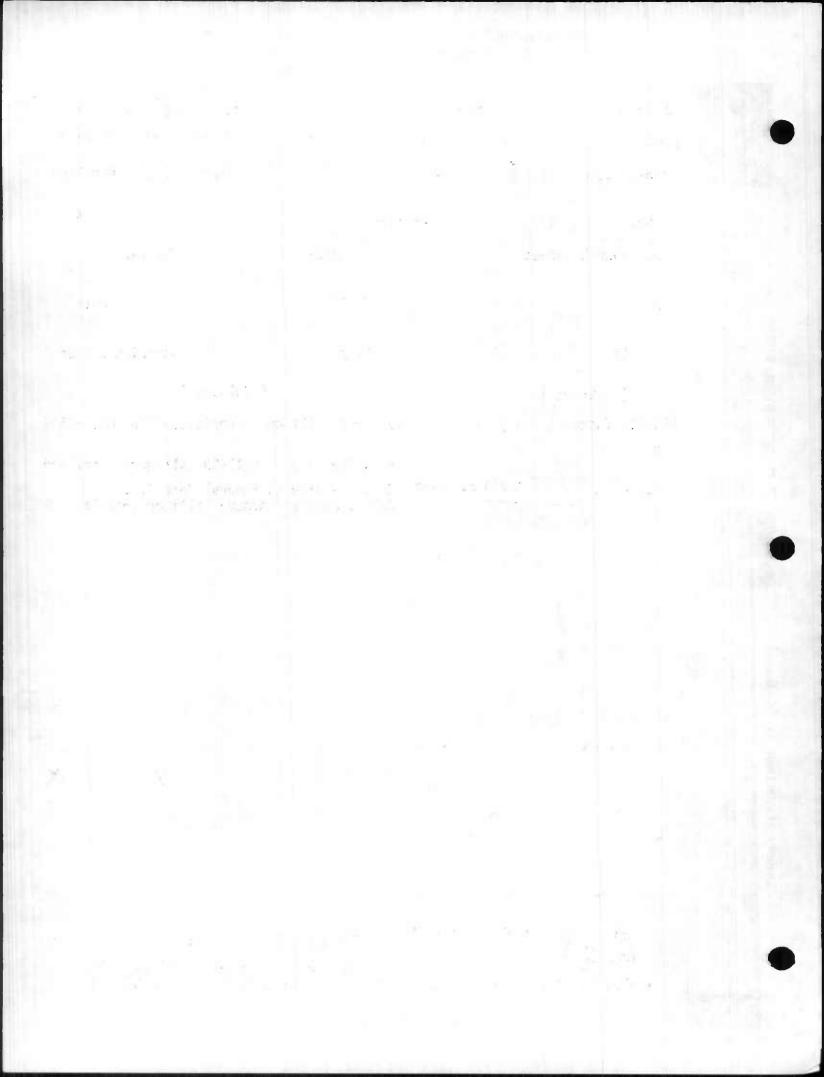
FOXFORD STREAM

3745

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** VANSTORY 6.10 PM JOANNE 10 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MERCY MEDICAL CENTER If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday)

Yrs. If Undar 1 Yaar 9. Birthplaca (Stata or Foreign Country) Maryland 5. Social Sacurity Number **Funeral** Sex 1□M 2 F Months Days 213325788 Director Usual Residence of Decedent 10d. Insida City Limits the Maryland 10c. City, Town or Location 10a. Stata 10b. County itam 27 is marked other than "natural", or items 23s or 28s-4 show other traumetic event, the Medical Examinar must be notified at Md Yas 2 No N/A **Baltimore** Director 10e. Streef and Number 10f. Zip Coda 10g. Citizen of What Country? with 1 5030 Westhills Road 21229 USA permit. Pages 1 and 2 should be filed within 72 hours aftar death a Department of Health and Mental Hygiena. In Introduction if it it it is marked other than "natural", or items 23a any injury or other traumetic event, the Medical Examiner must once. Funeral 12. Was Dacedanf Evar in U,S. Armed Forcas? 1 ☐ Yas ※ No If Yas, Giva Yaer or Datas: 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 3€ No Specify: **Black** Specify: by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry 15. Dacadent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) Clerk Balto City Gov't 12th 18. Mothar's Nama (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Preston Cornish 2 Helen Wallace 19b. Malling Addrass (Streat and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 816 Lyndhurst Street Baltimore, Maryland 21229 of Disposition (Nama of Local Data 20c. Location - City or Town, Stata Nikki D. Wilkins (Daughter) 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Woodlawn Cemetery 5/13/99 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Caple Funeral Service 21. Signatura of Funaral Sarvice Licansaa 5502 Winner Avenue Baltimore, Maryland 21215 enfar the disease, o complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death **Physician** 5 DAYS Immediata Causa (Final disaasa or condition resulting in deeth) /Medical BILATERAL SUBDURAL HEMATOMAS **Examiner** Dua to (or es e consequence of): Examiner IWEEK THROMBOCYTOPENIA AND COAGULOPATHY physician and the bunal-tran Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evanfs rasulting in daath) Last requires that the death certificate be execu RENAL FAILURE
Dua fo (or as a consequence of): 3 WEEKS Division of Vital Records, P.O. Box 68760, Physician/Medical 98 YEARS METASTATIC COLON/RECTAL CANCER USB 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Unknown 1 ☐ Yss 2 ☐ No þ 24b. Wara autopsy findings evailable prior to complation of causa Completed 24a. Wes en eutopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 No certificata Hospital or Attending Physician: funeral director, 25. Was casa refarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No P this 28c. Injury at Work? 27. Mannar of Daath 28b. Time of 28d. Describe how Injury occurred Certification: 28a. Deta of Injury (Month, Day Year) 1 Natural 5 Pending aftar death. 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Sulcida 28a. Plece of Injury - At homa, farm, streaf, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 ☐ Homicida 24 hours a edical 🔀 Cartifying Physician: To tha bast of my knowledga, deeth occurred at tha tima, data and place, and dua to tha causa(s) and menner es stated. 29a. Cartifian (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 the 29d. Data signed (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar . Date filed (MAY) a1 3ar) 1990

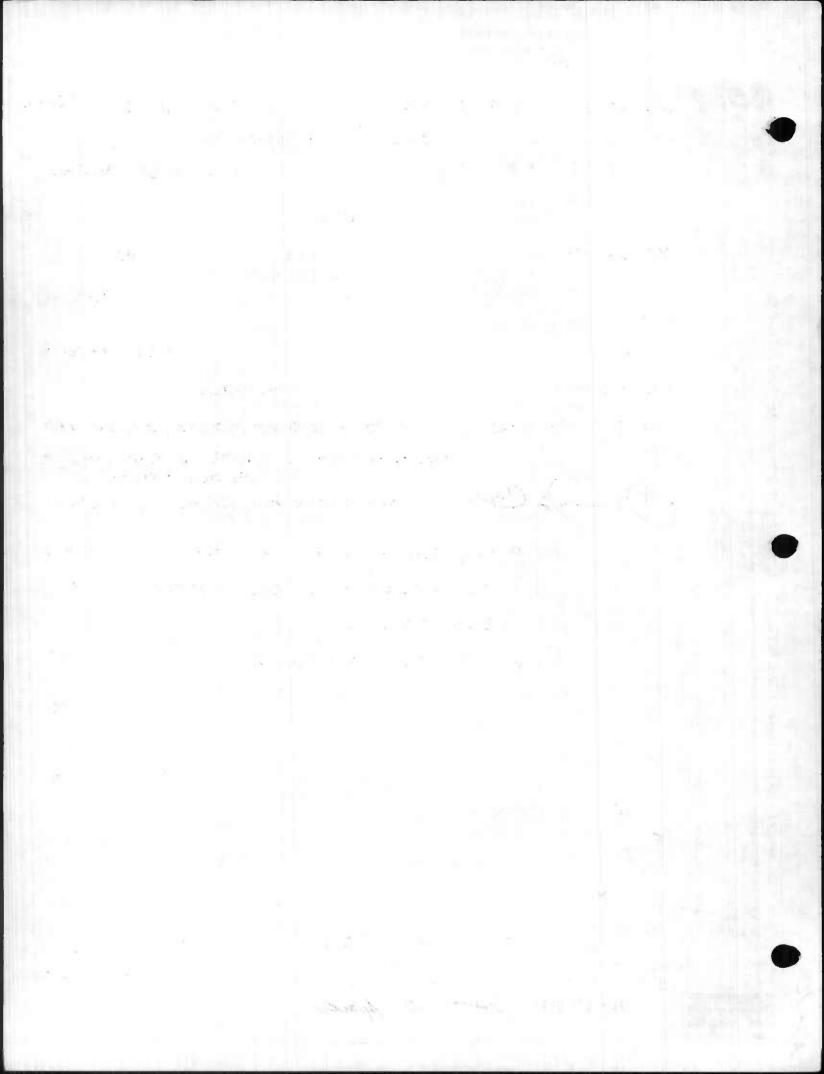
JOSEPH

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S. GREEN

ST.

BALTIMORE, MD 21201



	NC	ITEMS: #23 PART I.				ficate of	Health ar Death		Reg. N		156	1.7
VITHERSPOO		Decedent's Name (First, Middle,		MEU G/	710074			2. Date of D		0.	3. 1	ime of Death
Physician		TONY WITHERSPO	ON					Month MAY		8, 1999		21P.M.
/Medical Examiner	4.0	Fecility Neme (If not institution,	give street end number)				4b. City, Town	n, or Location of Dec		c. County of D		Z1F • 11.
LAGIIIIICI	_	937 RAMSAY STRE	ET				BALTIN	MORE		N/	A	
Funeral Director	5.	Social Security Number 217–70–1643	Sex 7. Ag	e (In yrs. las		Under 1 Yea lonths Days		Min. (Month, I	lirth Day, Year	9. 6	Birthplace (Country)	Stete or Foreign
	-	sual Residence of Decedent Da. State 10b. County		10c City 7	Town or Locati	ion					104 10	ide Cir. i Inite
sat be notified at rel Director		MD. N/A			TIMORE							ide City Limits XYes 2 □ No
be notified Director	1	De. Street and Number=				10f. Zip Code			10a. C	itizen of What	Country?	
		1939 RAMSAY ST				212	22			USA		
919	1	I Maritel Status	12. Was Decedent	Ever in U.S.	13. Was			n? (Specify Yes or I	lo-	14. Race - A	merican Inc	ien.
Funeral	1	1 Never Married 2 Merrie	Armed Forces?		If Ye	es, specify Cu	ban, Mexican, F	Puerto Rican, etc.)		Black, W		
A		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10	Yes 2 No	Specify:			Specify: B	LACK	
fed		15. Decedent's	Education	1	16a. Decedent	r's Usual Occi	upation e during most o	d ward in a	16b. I	Kind of Busine		
iple	-	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	tife. DO	NOT use retir	e during most o red)	Working				
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Be	3 17	Father's Neme (First, Middle, La EARLY WITHERSP						Name (First, Midd IMA YOUNG	le, Maide	n Sumame)		
0	-											
	1	9a. Informant's Name/Relationship						or Rural Route Num				
	-	SHEILA WITHERS	POUN (SISTER				YETTE A	VE. BALT				
	20	a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3	☐Removal from State	cem	e of Disposition of D	ory or other pl		Date	20c. l	Location - City	or Town, S	ate
		4 Donetion 5 Other (Spe		ARBU	TUS ME			5-15-99	BAL	TIMORE	MAR	YLAND
	2	Signature of Funerel Service Lie	censee/		1			PHILLIPS	FUNE	ERAL HO	ME, P	.A.
		Varcita S	ectr of	50	172	21-27 N	. MONRO	E ST. BAI	LTIMO	DRE, MA	RYLAN	D 21217
	2	 Pert1. Enter the disease, or co shock, or heart feilure. List or 	implications that caused by one cause on each lin	the death.	Do not enter the	he mode of dy	ying, such as ca	rdiac or respiretory	errest,		Inten	el Between
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amine			b								1	
	if	equentially list conditions, any, leeding to immediate		Due to (or a:	s a consequer	nce of):					1	
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200	th	ause (Diseese or injury eat initiated events	■ d				given in Part I.					ause of death?
Physician/Medical	C th	ause (Disease or injury at initiated events suffing in death) Last	■ d				jiven in Part I.		d tobacc		ute to the c	ause of death?
by Physician/Medical	C the re	ause (Disease or injury at initiated events suffing in death) Last	■ d				jiven in Part I.	1[24a. Wi	Yes	2□ No 3□	Probably	4 Unknow
by Physician/Medical	C the re	ause (Disease or injury at initiated events suffing in death) Last	■ d				jiven in Part I.	1[24a. Wi	Yes	2□ No 3□	b. Were au available completi	dopsy findings prior to on of cause
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State Registrar

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31. Dete filed (Month, Day, Year) MAY 1 2 1999

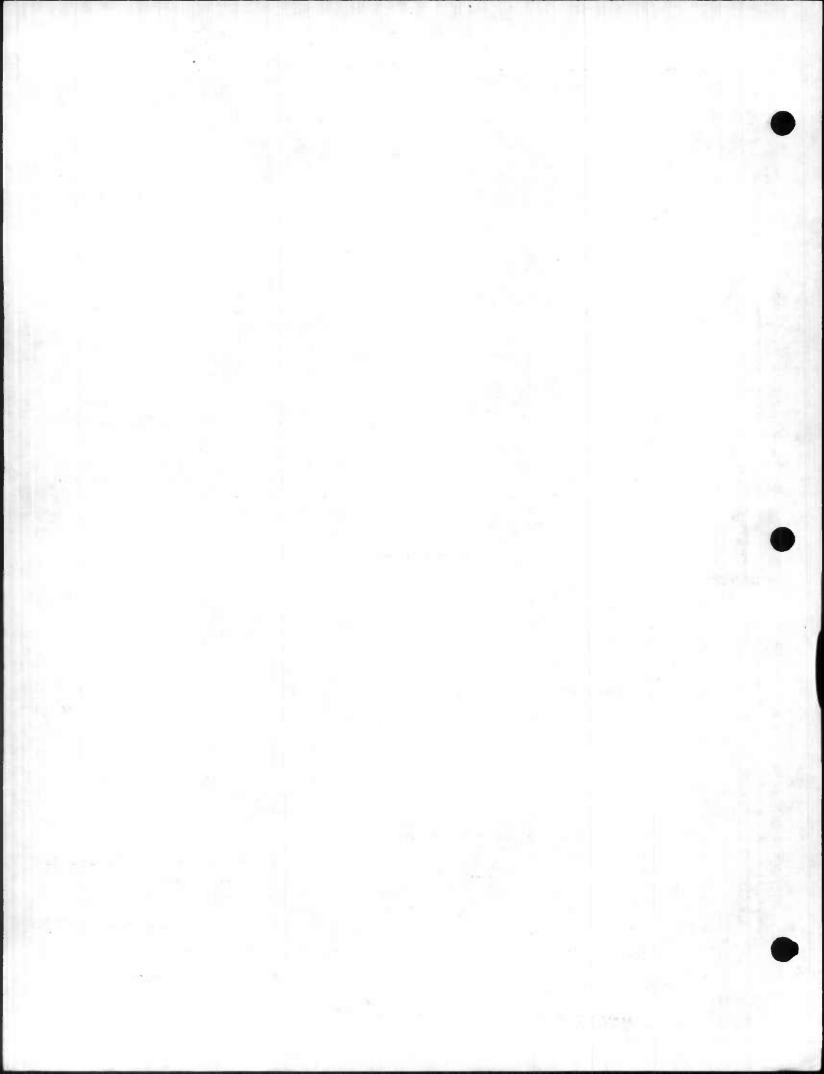
30. Name and address of person who complete beause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature

DHMH 16 Rev 6/95

O.C.M.E.

MAY 9,1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

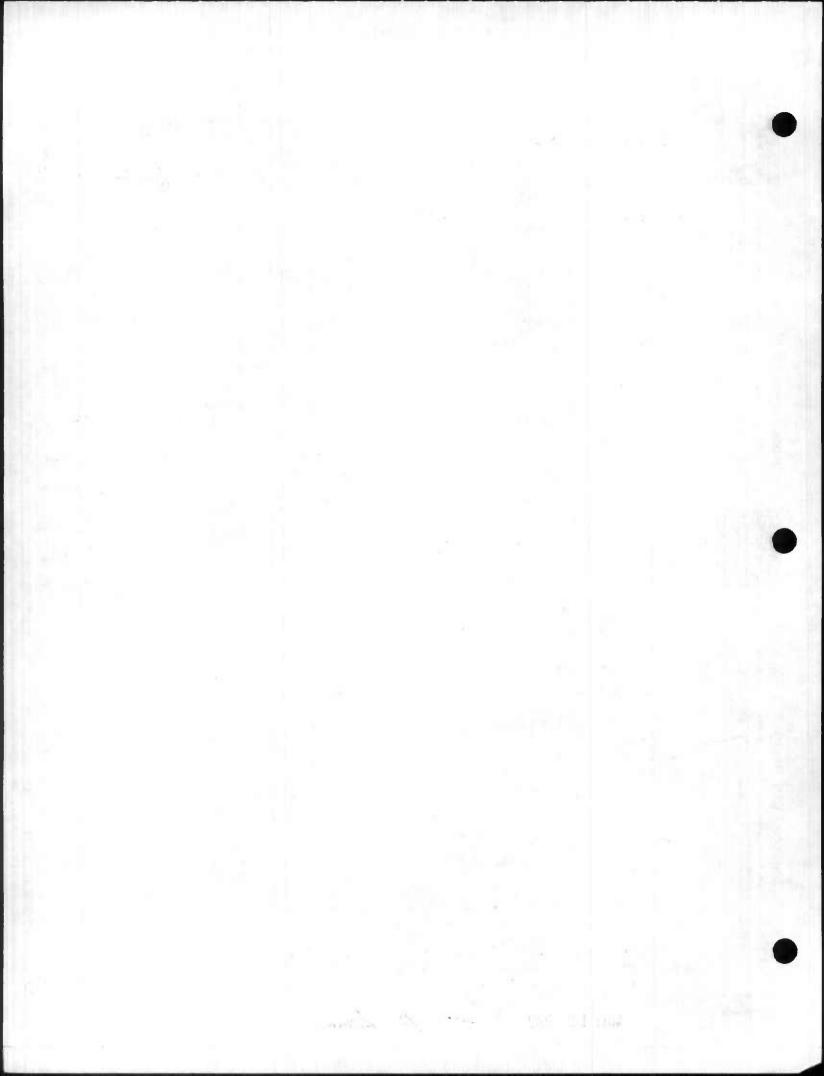
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 10, 1999 Velvie M. Woolwine 11:50 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3619 Hickory Avenue Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2€XF Deys 85 Yrs. 17, 1913 West Virginia 234-32-6720 Director Usuel Residence of Decedent 10a Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits XX Yes 2 No Maryland N/A Baltimore 28e-f Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be n 3619 Hickory Avenue 21211 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Sfetus 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 8 1 Yes XX No Specify: Specify: White þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ment of Health and Mercal Hygiene. ant if them 27 is marked other than "1 ury or other traumwift event, \$18 Med Elementery/Secondary (0-12) College (1-4or 5+) Can Inspector Can Manufacturing 6 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Ε. Dickens Hillary Sarah Simpkins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Allen Woolwine (Son) 806 W. 35th Street Baltimore, Maryland 21211 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 5/14/99 Baltimore, Maryland 21. Signeture of Furnirel Service Licensee 22. Neme end Address of Fecility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or have feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury fhet initiated events resulting in death) Last Box 68760. Due to (or as a consequence of): Division of Vital Records, P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? page 2 should 1 Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certifical of in by the funeral director, i or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home SP Residence 6 Other (Specify) 1 Yes 2 No 26a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

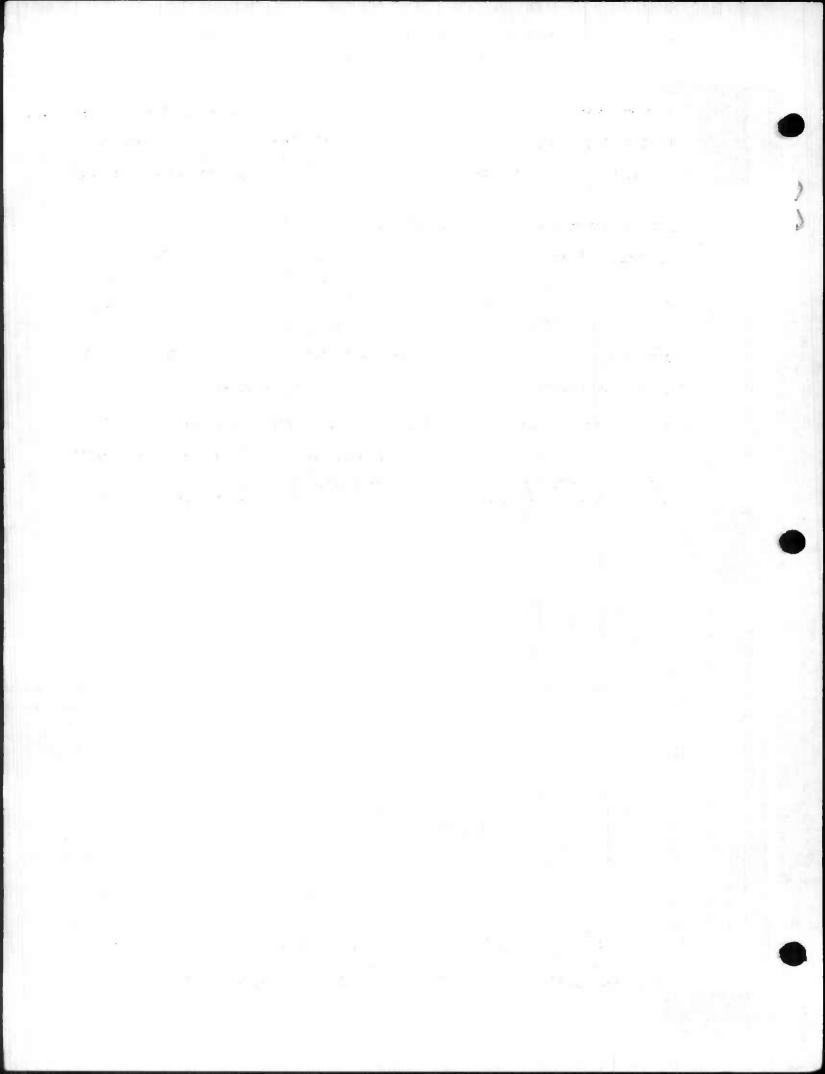
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture end itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23076 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) DI Am mo 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

AMS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey May 1999 9:00A.M. 8, Young Pansy R. 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Anne Arundel Pasadena 266 8th Street If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Months Deys 1□M 20 F Yrs. Oct. 27,1930 Maryland 212-36-2036 Usuel Residence of Decedent 68 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2™ No Maryland Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 266 8th Street 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) North Arundel Hospital L.P.N. 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Mildred Grant Raley Thomas 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 266 8th Street Pasadena, Maryland 21122 William H. Young (Husband) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 5/12/99 Gardens of Faith Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21 Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. Collins 3204 Mountain Road Pasadena, Maryland 21122 23e. Pert Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervet Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) END STAGE LIVER RENAL DISEASE END STAGE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): HYPO ALBURENE MIA Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No MELLITUS T 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 Yes 20 No 1 Yes 2 No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury el Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Division of Vital Records, P.O. i or Attending after death. Director: After ne Hospital or Atte n 24 hours after de ne Funeral Directo pletely filled in by ti

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Baltimore,

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Certification:

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4 Homicide

(Check only one)

29b. Signeture end title of certifier

29e. Certifier

29c. License number D0035706

1X Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner stated. 29d. Dete signed (Month, Day, Year)

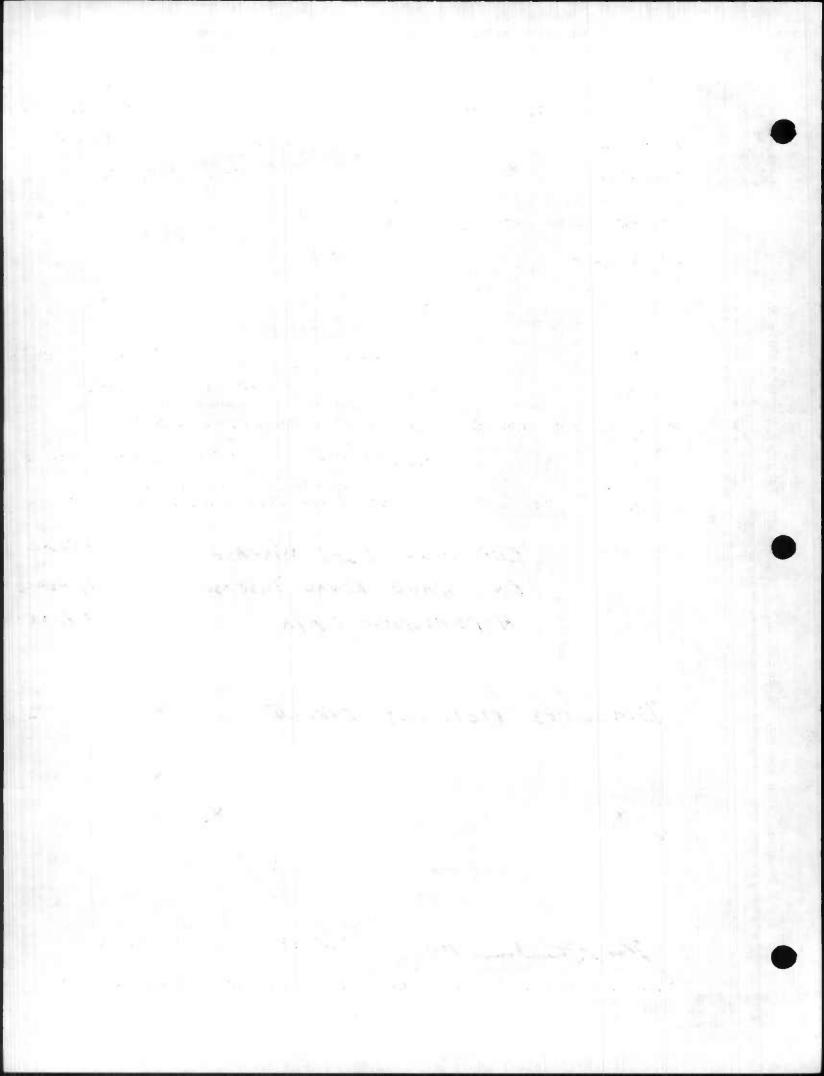
May 11, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Elias C. Ghandour, MD, 5601 Loch Raven Blvd., Baltimore, MD 21239

32. Registrer's Signature Souls!

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** ZEBROWSKI 1.05 AM 05 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A BALTIMORE BON SECOURS HOSPITAL If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1□M 2√2F 214-18-7540 Yrs. Director 94 JUNE 14,1904 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours efter death with the Menyland nent of Heaith and Mentel Hygiene. 10c. City. Town or Location 10d, Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No BALTIMORE MARYLAND N/A Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. Funerai 706 DEVONSHIRE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Biack, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced WHITE Year or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) OWN HOME HOMEMAKER 8TH GRADE 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ANNA BOOKER EDGAR LEWNS 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) permit. Pages 1 and 2 s Department of Heaith ar Important: If item 27 is any Injury or other trau 1931 ALTAVUE ROAD - CATONSVILLE, MARYLAND 21228 ELMER W. LEWNS (BROTHER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriat 2 Cremation 3 Removal from State 5/11/99 4 □ Donation 5 □ Other (Specify) Mausoleum LOUDON PARK CEMETERY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Faci HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory errest, or heart faiture. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medical immediate Cause (Finat disease or condition resulting In deeth) Examiner Examiner The law requires that the death certificate be executed strending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medicai Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 6 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Was an autopsy hes s certificate headinector, page 2 1 Yes ONO 1 TYee 2 No To the Hospital or Attending Physician: I within 24 hours effer death.

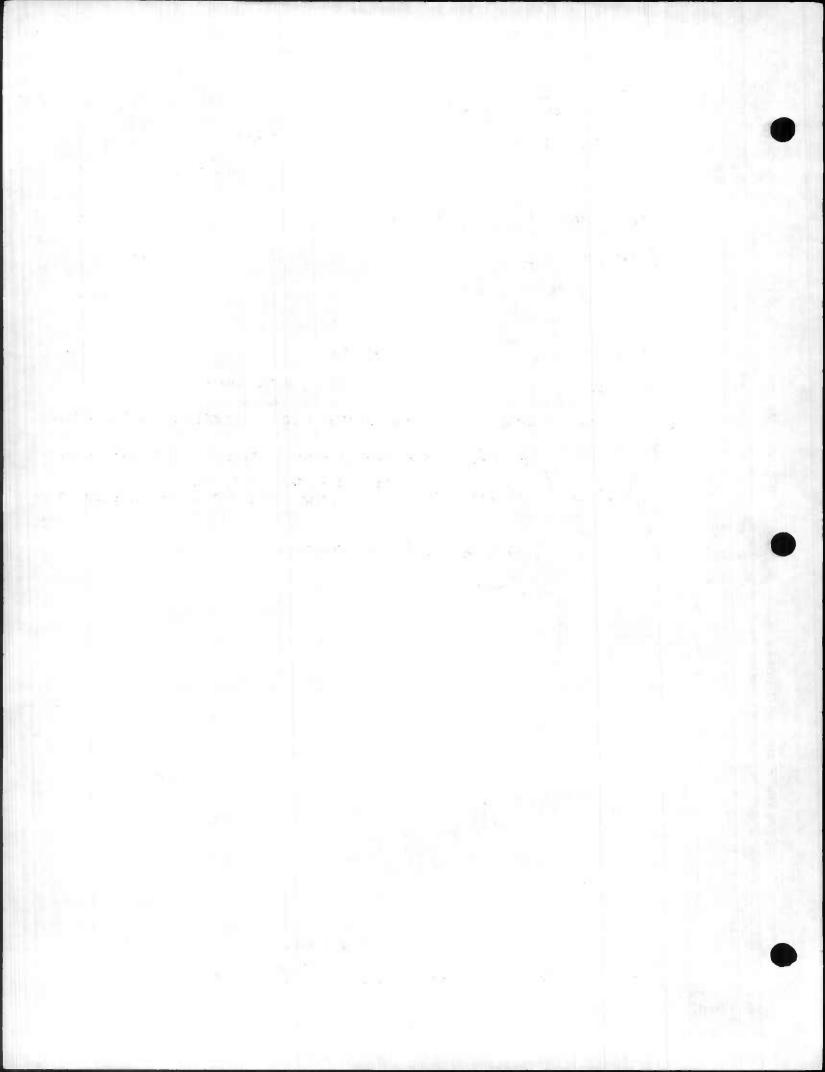
To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Yeer) 27. Manney of Deeth 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2/N-EUTOW

State Registrar 31. Date filed (Month, Dey, Year) 3 1999 MAY

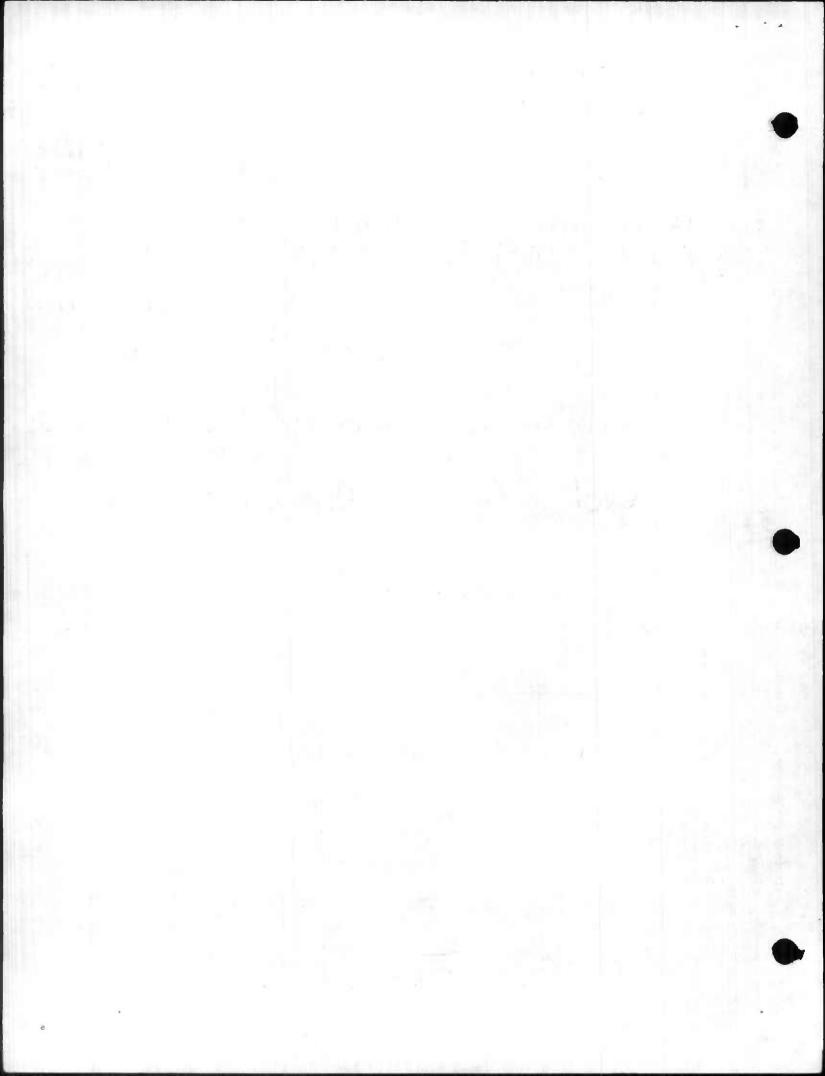
-CAQA

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5652 Certificate of Death AMEND#8 PER F.H. G772 6-3-99 J.A. Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11,1999 MAY 12:56 am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of D Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL 5. Social Security Number 219-38-43 If Undar 24 Hrs 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y Birthplace (State or Foreign **Funeral** Months Davs Hours 1 M 2 □ F Yrs. Director Usual Residence of Decede death with the Meryland 10a. Steta 10b. County 10d. Inside City Limits 10c. City. Town or Location man be notified at 1 Yes 2 No Funeral Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? do 6 Herma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Wes Decedent Ever in U,S Armed Forces? American Indian, 11 Marital Status Black, Whita, etc. filed within 72 hours efter 2 No 1 Nevar Merried 2 Married ☐ Yes ò 21215-0020 1 Yes 2 No Yes Give Specify by 3 Widowed 4 Divorced American Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working jife. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry I Hygiene. Elementary/Secondary (0-12) lege (1-4or 5+) bore 0 Pages 1 and 2 should be filed nent of Heelth end Mental Hygis int: If Nem 27 le marked other Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame, Be orman round Se 19e. Informent's Neme/Raletionship (Type, Print) (Sister 19b. Mailing Address (Street and Number or Rural Routa Number, City or oretta a. onvers 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 □Removel trom State 三百 Department of Important: If eny injury or other owne. 4 ☐ Donetion 5 ☐ Othar (Specify) in of Funeral Service Licer 22. Name and Address of Fecility
JOSEPH
2222 W. North 21. Sic Aue W. North 212 or the dilbase, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, must fail ris. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in deeth) PULMONARY EMBOLISM SEVERAL HOURS Examiner Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE HOURS the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initieled events resulting in death) Last Due to (or as a consequence of) DAYS TO The law requires that the death certificate be axe P.O. Box 68760, MONTHS Physician/Medical Due to (or es a consequence of): US6 85 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by t ahould be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed 24e. Wes an autopsy parformed? 24b. Were autopsy tindings available prior to completion of cause of death? page 2 hes 1 Yes 2 No 2 No certificate Attending Physician: director. 25. Was case reterred to medicat examiner? Be 28. Placa of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Magnar of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding Investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be detarmined 28e. Place of Injury - At home, term, street, factory, office building, atc. (Specify) 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide ò 24 hours e Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29a. Cartifier (Check only one) within 2 \$ 29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D41128 MAY 13,1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) CHANMUGAM, 600 N. ARJUN WOLFE STREET BALTIMORE, MARYLAND 21287 31. Dete tiled (Month, Day, Year) Registrer's Signature State 4 1999 MAY Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #11 PER ANATOMY BOARD G781 3-8-2000 WR. Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month Yes **Physician** May 2 1999 6:20 am Arthur Bradley /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Park Montgomery Tokoma If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In vrs. lest birthday) Birthplace (Steta or Foraign Country) 6. Sex **Funeral** Months Days 1X M 2□ F 62 Sept.8, Director 577-48-9323 North Carolina Usuai Residence of Deceden the Marylend 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 3 ☐ No Director Maryland | Montgomery Langley Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8206 14th Avenue 20783 U.S.A. Funeral deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? unknown 1 □ Yas 2 □ No If Yes, Give 11 Marital Status 14. Race - American Indian, Black White atc filed within 72 hours after 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white à Yaar or Dates: 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown Driver Taxi/transportation Pages 1 and 2 should be filed vent of Health and Mentel Hygient: If Item 27 is marked other t 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) unknown other 20a. Mathod of Disposition 20b. Placa of Disposition (Name of Date 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 8 permit. Pege Department of Important: If any injury or 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licansae 22. Nama and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 23a. Par I. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onsat and Death **Physician** /Medicai Immediata Cause (Final . ISHEMIC CARDIOMY OPATHY disease or condition resulting in death) Examiner Examiner SHEMIC BOWE the burief-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Due to (or es a consequence of) pue MYLOCARDIAL INFARTION ANTERIOR P.O. Box 68760. physician Physician/Medical ettending p ARTERY ARY DISEASE ORON signed by the e Part ii. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown COLITIS þ Records. 24b. Were autopsy findings evallable prior to completion of causa of death? 24e. Wes an autopsy Completed HEART FAILURE Deen HYPER TENSION PULMON ARY 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No. 25. Was cese raferred to medical axaminer? Be 26. Placa of Deeth (Check only one) 2

this certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica Certification:

1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Dev Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 □ ER/Outpatient 3 □ DOA 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending investigation 1 Natural 2 Accident

1 Yes 2 No 6 Could not be datarmined 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner stated.

29b. Signature end title of certifiar 29c. License number 29d. Data signed (Month, Dey, Year)

30. Nema and addrass of person who completed ceuse of deeth (Item 23e) (Type, Print)

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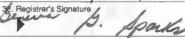
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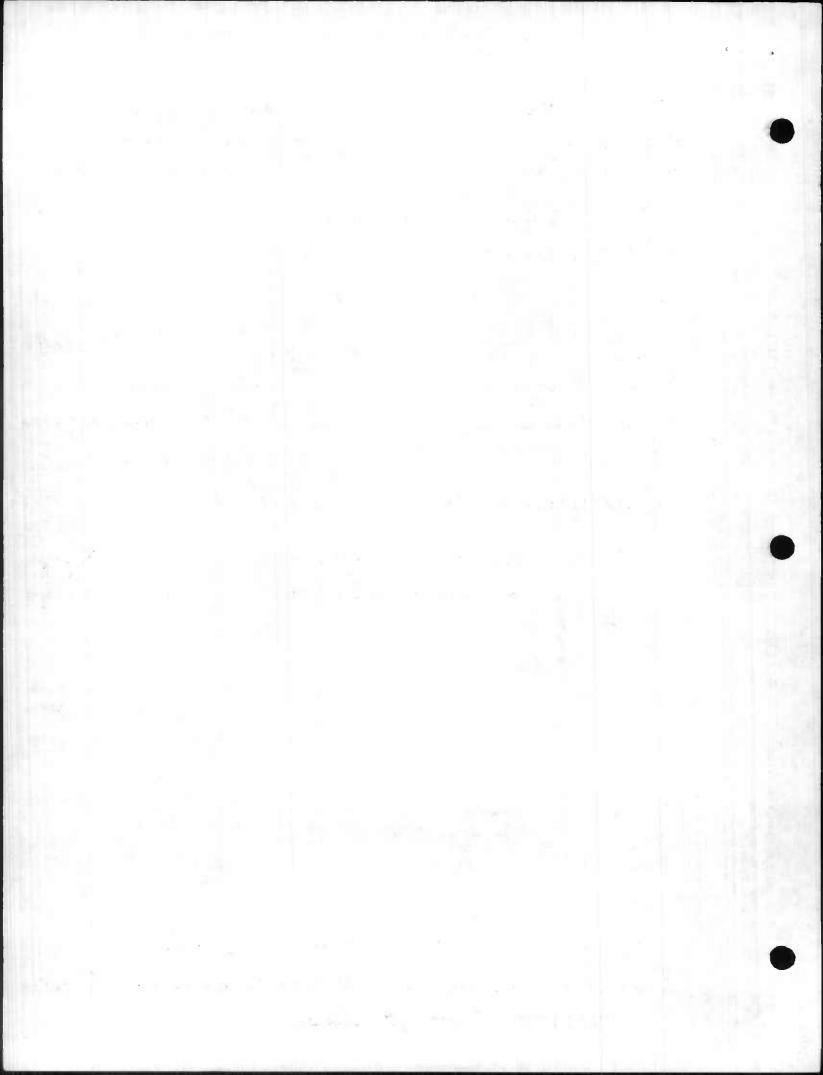
To the Hospital within 24 hours e

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death Month **Physician** 14 1999 J3LACKMOORE 12 JANDERS /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Randallstown Baltimore Hospital North west If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4 - 25 Birthplace (State or Foreign Country) 6. Se 5. Sociel Security Number 7. Age (In yrs. last birthday) -07-7879 1♥M 2□F Deys Hours Min 213-07-7879 Usual Residence of Decedent Yrs. .C. Director with the Marylend 10e. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Examinar must be notified at Md 1 ☐ Yes 2 No Baltimore andallstown Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whef Country? 3824 Court 21244 Lakes Funeral 14. Race - Americen Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Merifal Status permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mentel Hygiene. Important: If Itam 27 Ia marked other then "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) etal 9th grade utter NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Blackmoore Georgianna To 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall town Nd 21244 Blackmoore-Daughter 3824 akes OHnne w 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State any injury or Meyonal Park 5-18-99 4 Donation 5 □ Other (Specify) butus 21. Signature of Funeral Service Licensee Name and Address of Fecility arch F.H. West Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto Md ZIZIS Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) PHEUMONIA ASPIRATION **Examiner** Due to (or as a consequence of): Coilera Examiner buriel-tren Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury fhat Initiated events resulting in death) Lest Due to (or as e consequence of) pue The law requires that the death certificete be exec Division of Vital Records, P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of): 88 950 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of deeth? hes certificate 2/5 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dnpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury ef Work? 1 Natural 5 Pending efter death. Director: Aft 1 🗆 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours e Funeral D 29a. Certifier 1🔂 Cartifying Physician: To the best of my knowledge, death occurred at the time, defe and plece, end due to the ceuse(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 10 o.m. allamo D41410 30. Name and address of person who completed cause of death (item 23a) (Type, Print) MD MOSPITAL CENTER RANDAUSTUMN JOGINDER PMEHTA NORTHWIEST 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State boards Registrar MAY 1 4 1999

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Day Month 1503 PM MAY 9, 1999 Norman J. Bethea, Jr 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5430 PARK HEIGHTS AVENUE APARTMENT 414 BALTIMORE If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 9-17-1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) Deys Months Hours 1 ☑ M 2 ☐ F 53 Yrs. 218-44-3749 Md Usuat Residence of Decedent 10a. Stata 10b. Counts 10c. City, Town or Location 10d. Insida City Limits 1 Vas 2 No N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5430 Park Heights USA Avenue 21215 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc 1 Never Married 2 Married specify: Black 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry Unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) NA Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 88 Norman J. Bethea, Sr Alice Chance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Charleswood Court Barbara Bethea - Wife Baltimore, Md 21207 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1)(Burial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5-15-99 Randallstown, Md 22. Nama and Addrass of Facility
March F/H west 21 Sin ire of Funeral Service Licensee 0 4300 Wabash Avenue Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final altypertensive atheroscleretic cardiovascular diseasa or condition resulting in death) Due to (or as a consequence of): disease Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or es a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy INSPECTION 1 Yes XXNo 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1X Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 | Naturel
2 | Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

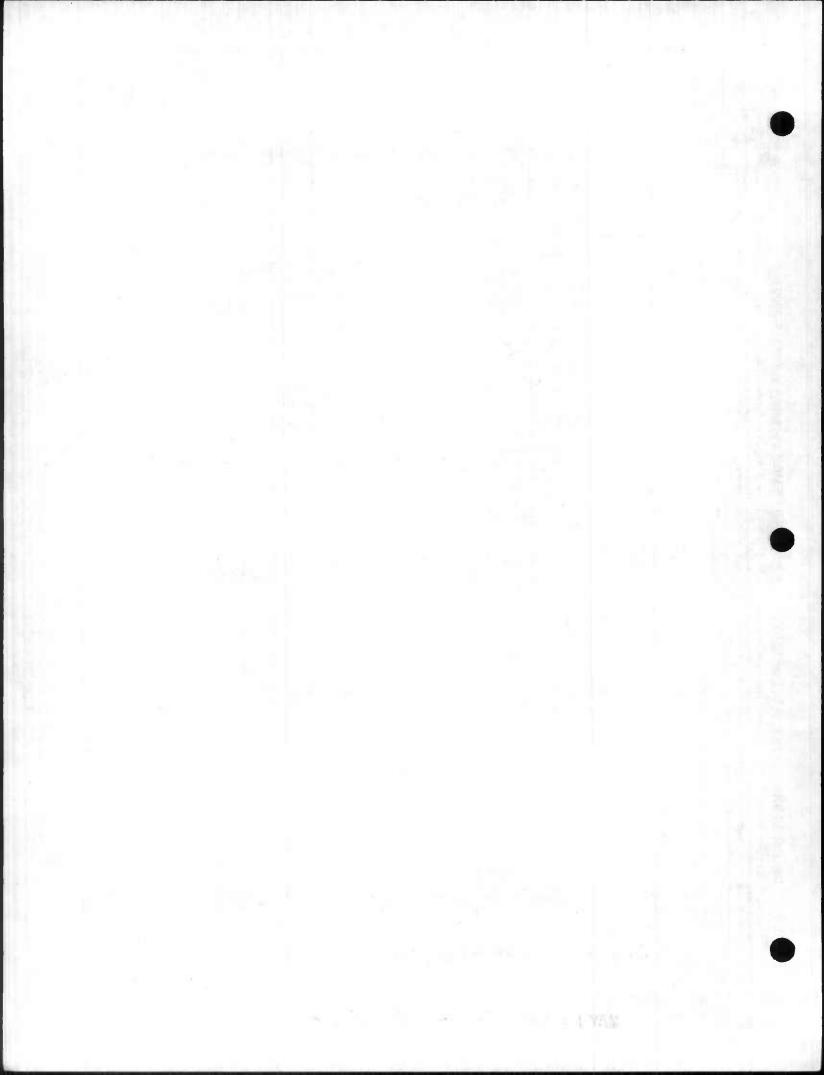
**Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. MAY 10, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Stephen Radentz, M.D.

State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

31. Date filed (Month, Day, Year)

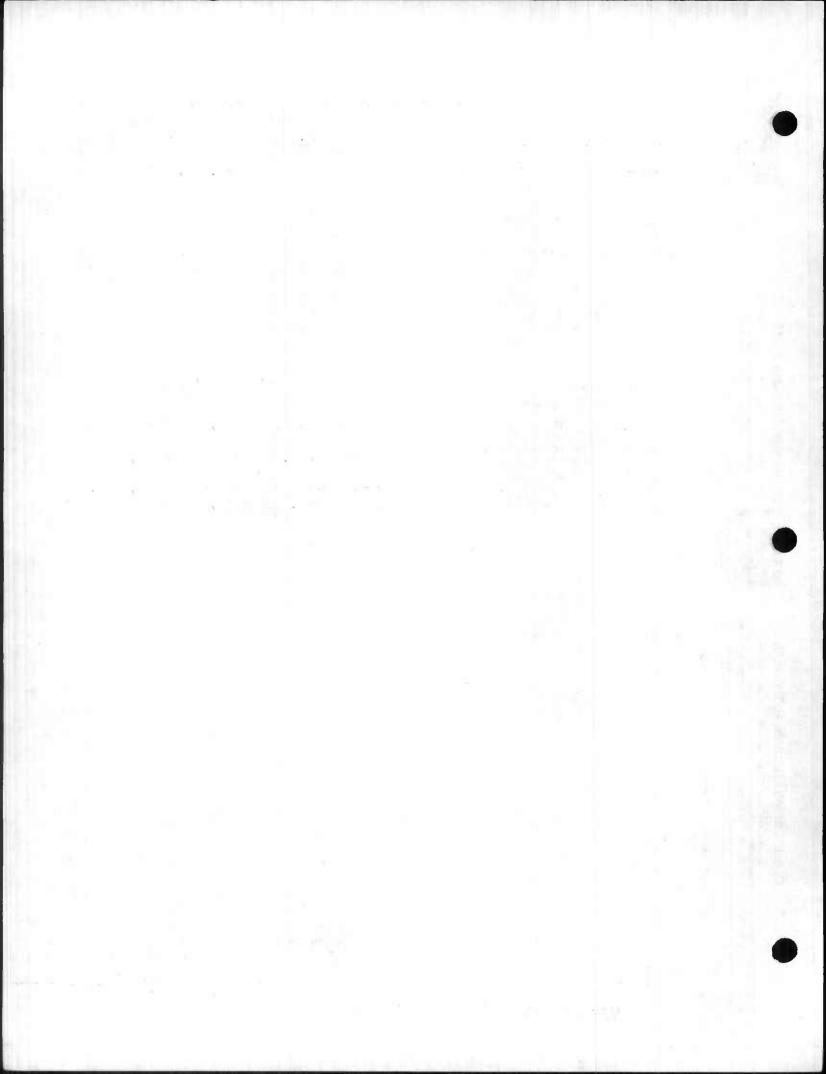


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State of Maryland / Department of Health and Mental Hygiene

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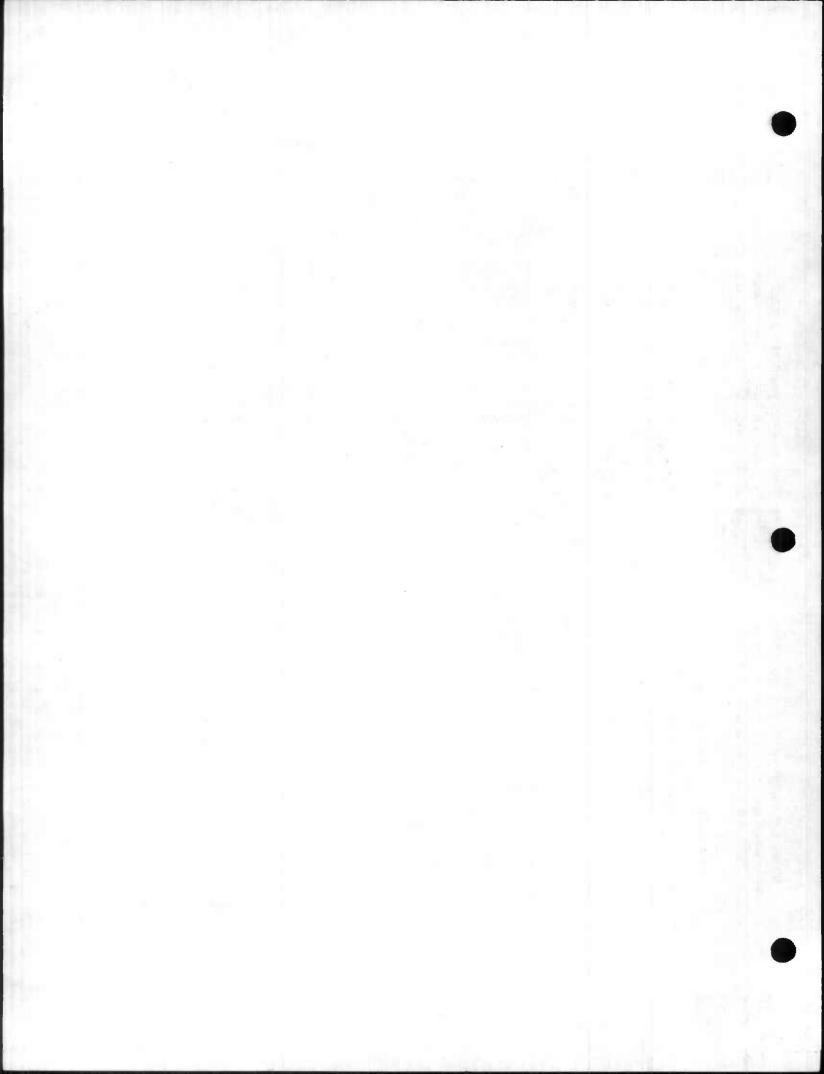
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_ 5 2 2	by Funeral Director		12. Was Decedent Eve Armed Forces? 1 DYes 2 No If Yes, Give Yeer or Detes: WW		13. Was Decedent of H If Yes, specify Cube	lispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	e - American Indi ck, White, etc.	an,
21215-0020 d within 72 hours efter giene. wrthan "netured", or Ne	Completed	15. Decedent's Edu (Specify only highest grade Elementery/Secondery (0-12)	cation		ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	etion during most of work 1)	ing	16b. Kind of Bu	usiness/Industry	
d 2121 filed within Hygiene. ther then	Con	12 17. Fether's Neme (First, Middle, Last)		Pu.	llman Porte	18. Mother's Name	o /Eiret Middle	Railro		
Maryland 2 d 2 should be filed th and Mental Hygi 7 is marked other traumatic avent.	To Be	Robert T. Brown,	Sr.			Beatrice			10)	
Mar d 2 sho th and 7 ie m		19e. Informent's Neme/Relationship (Ty Jacqueline Kakembo	, ,		Heiling Address (Street 10055 Quant				State, Zip Code) 21046	
Baltimore, Maryland : permit. Peges 1 and 2 should be filed Department of Health and Mental Hyd important: If them 22 is marked other any injury or other traumatic avent.		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ P	lemovel from State	20b. Plece of D cemetery,	isposition (Name of crematory or other place	(se) Ma	ayDete	20c. Location -	City or Town, St	ate
Baltimo permit. Pege Department of traportant: If eny injury or		4 □ Donetion 3 □ Other (Specify) 21. Signeture of Funerel Service Licens		AIL./Wo	ash. Cremat		14, 1999	Laure	el, MD	
W FOF	DUC.	Dande L	Lamaran		Witzke Fur. 5555 Twin	eral Home	es, Inc.	mbia MT	21045	
Physicia	an	23a. Pert1. Enter the disease, or complishock, or heert feilure. List only or	icetions that caused the ne ceuse on each line.	deeth. Do not	enter the mode of dyir	ng, such es cardiac	or respiratory en	rest,	Appro	oximete el Between t end Death
/Medic Examin		Immediate Ceuse (Finel disease or condition resulting in death)	· Uppe	9 - e to (or as e co	T bleed	2			4	days.
De is	niner		Dude	A						2. 425
\$8760, icate be executed physicien end s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	101	a to (or as a con	1	monic	'e		2	WKs.
ox 68760, certificate be ex iding physicien ise as the buria		that initiated events resulting in death) Lest	COPT	to (or as a cor	sequence b():				7	YN
Box death cert a attendin d for use	iciar	Part II, Other significant conditions cor	stributing to death but n	ot resulting in th	na undarlying cause nis	en in Part I	23h Did t	nhacco usa co	ntribute to the c	ause of death?
cords, P.O. Box (requires thet the death certit been signed by the attending should be detached for use a	y Physician/M		asslyft		Here all the traces	or arr or .			3/2 Probably	
	Completed by		/				24a. Wes o	en eutopsy med?	24b. Were eut evailable completic of death?	prior to on of cause
Vital Re- ulcion: The lay certificate has irector, page 2	Com						101	es 20 No	1 □ Yes	2 No
Vita clen: sertific ector,	Be	25. Was case referred to medical examiner?	lospitel:		other actions of	26. Place of Deat	h (Check only o	ne)		
Ing Physics of After this countries of the countries of t	ion: To	27. Menner of Death 1 Presumer of Death 1 Presumer of Death	28a. Dete of Injury (Month, Day Ye	2 ER/Outpo	ne of 28c. Injur	y at k?	ome 5 Resid			
or Attend infer deeth Director: in by the	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (5 City or Tow	Street and Numb m, State)	per or Rural Rout	a Number,
Division of Vital Re To the Hospital or Attending Physicien: The is within 24 hours after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	edicai Ce		ofclan: To the best of more: On the besis of exe end menner steted	aminetion and/o						ause(s)
To the To the	M	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	d (Month, Day, Y	'ear)
		30. Name and address of person who co		/Item 22a) /T-	Dint	4974				
		CHARU MEHTA,	4D, 8775	C(04	deap ct	-, #22	4, 001	umbia	, MD=	21045
	State	31. Date filed (Month, Dey, Year)	32. Registrer's	Signeture	1 1					

State Registrar

MAY 1 4 1999

32. Registrer's Signeti

B. Sparks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year CHRISTIAN BOETKER 12 4:00 am May 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1248 Brietwert Avenue Anne Arundel Odenton 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Ye 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours XIM 2DF 218-10-6781 Sept. 13,1906 Maryland **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Odenton 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1248 Brietwert Avenue 21113 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 1924–25 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Statue 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Printing Bookbinder-Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Christian Boetker, Sr. Anna Hefner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn L. Boetker (Wife) 1248 Brietwert Avenue, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 05/17 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD GAMBRILLS MD 21054 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myo carded infaction 3 hrs Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): th?

Physician /Medical Examiner

Department of Important: If eny injury or page.

Pages 1 and 2 should be filed withir nent of Health and Mentel Hyglene. ant: If frem 27 la marked other than ary or other traumatic avent, the Mark

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at

Funeral Director

Completed by

filed within 72 hours efter deeth with the Maryland

Baitimore, Maryland 21215-0020

Examiner the buriel-transit or Attending Physician: The lew requires that the death certificate be assecuted Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p à Completed the funeral director, Be Medical Certification: To this After To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completaly filled in by the fi

	d	
art II. Other significant conditions co	ntributing to death but	not resulting in the underlying cause given in Part t.
Congeshu	heart	failure

. Other significant conditions	contributing to death but n	ot resulting in the und	lerlying caus	e given in Part t.	23b. Did tobacco use co	ntribute to the cause of dear
Congeshu	- heart	failure			1 Yes 2 No	3 Probably 4 Unknown
,					24a. Was an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of death?
						10163 20160
/as case referred to medical xaminer?				26. Place of Dea	th (Check only one)	
☐ Yes 2☐JN6	Hospitat: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing H	ome 5 12-716sidence 6 □Ott	ner (Specify)
anner of Death	28a. Date of Injury	28h Time of		Injury at	28d. Describe how injury occur	rred

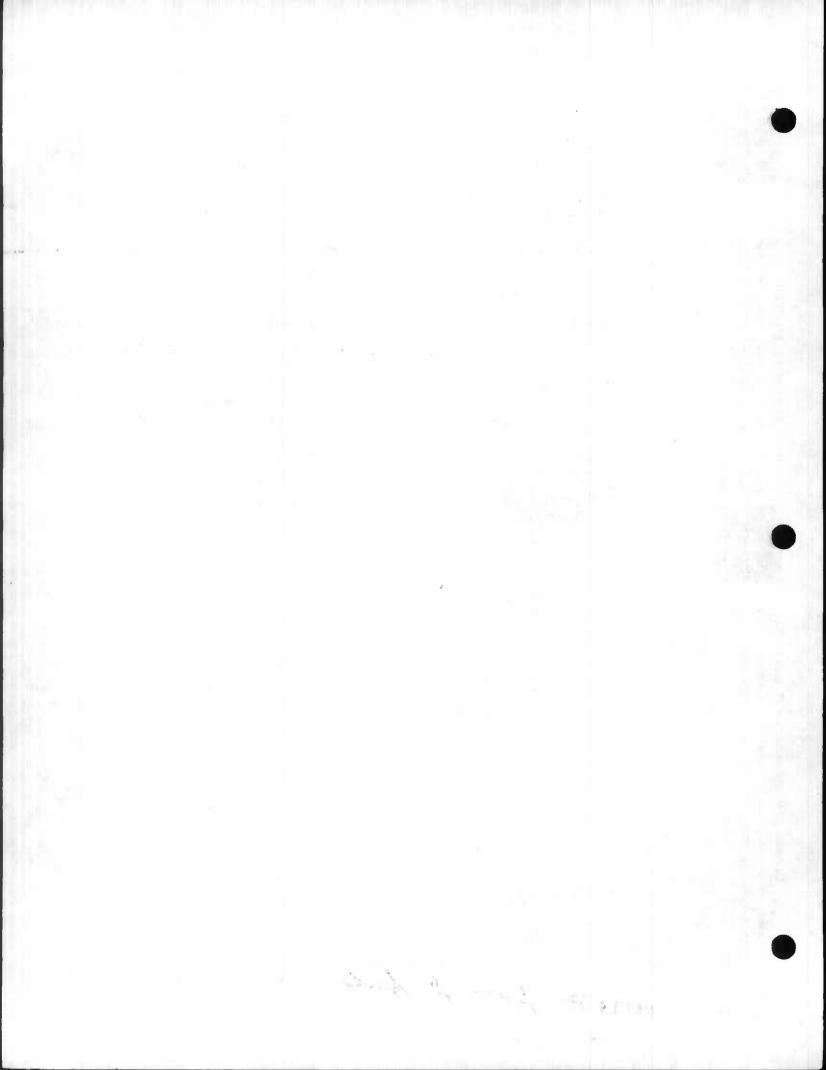
		1 Yes 2027No 1 Yes 2 No
25. Was case referred to medical	26. Plac	e of Death (Check only one)
examiner? 1 Yes 2 JN6	Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N	ursing Home 5 Pf6sidence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of linjury Nort? 1 ☐ Yes 2 ☐	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
20s Cartifier 17 Cartifutes Ph	resident. To the heat of the broadedes, death assumed at the time, date a	and alone and due to the annuals) and manner at stand

29a. Certifier (Check only one)		edge, death occurred at the time, date and place, and due in and/or investigation, in my opinion, death occurred at the	
29b. Signature an	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

D 23624

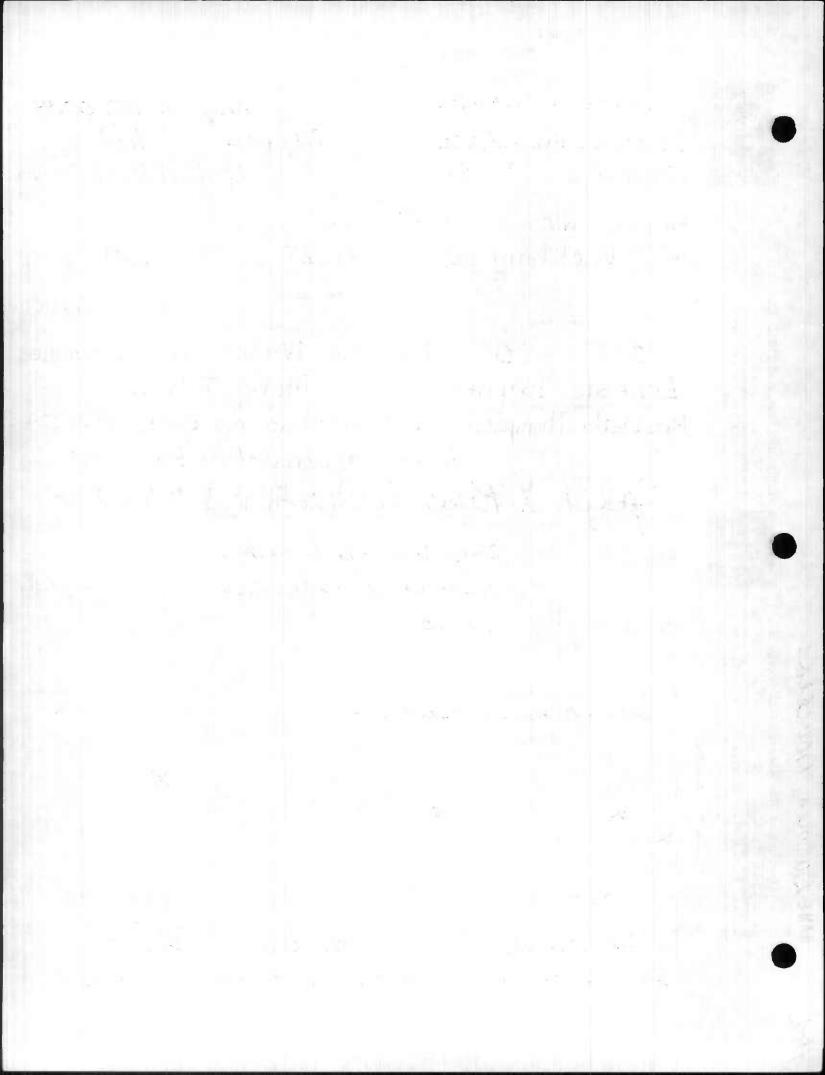
ed cause of death (Item 23a) (Type, Print)

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BARNES MOVELLA may 2 /Medical 4b. City, Town, or Location of Co. 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Agnes Health BALtimore If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth 918 North Carolina 7. Age (In yrs. last birthday) **Funeral** Months Days 239-24-2092 Usual Residence of Decedent 1□M 2XF Hours Yrs. Director with the Marylend 10b. County 10a. State City, Town or Location 10d. Inside City Limits th end Mentel Hygiene. 7 is marked other than "natural", or itema 23a or 28a-f show traumetic event, the Medical Examinet must be notified at saltimore 1 XYes 2 □ No Directo 10g. Citizen of What Country? 10f. Zip Code am permit. Pages 1 and 2 should be filed within 72 hours efter deeth to Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or itema 23set Injury or other traumetic event, the Medical Examples master. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No It Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: African American p 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ar 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Ru salto, Md. 21229 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Josep Approximate Interval Between Onset and Death Physician Congestive heart Failure /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner 2 week physician end s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASCNA Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 80 esn Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 | Yes 2 | No p 24b. Were autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed After this certificate has funeral director, page 2 1 ☐ Yes 2 ☐ No Barnes, 25. Was cese reterred to medicei examiner? 26. Place of Death (Check only one) 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No ofter deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the F within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26256 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) B1~U Washington Baltmore 700 DUSNEr 32. Registrar's Signeture 31. Dete tiled Month, Day, Yaar 999 State Registrar



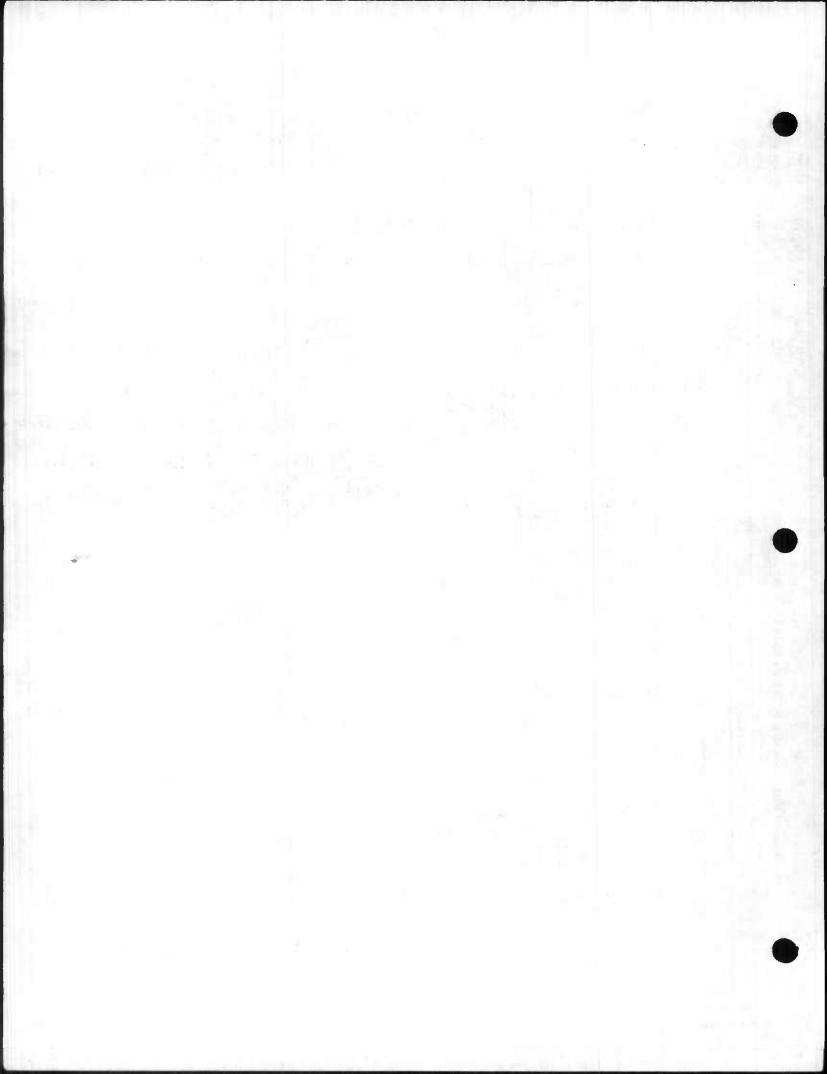
DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year 2:10 P.M. 1999 4b. City, Town, or Location of Deeth 11, Lorraine Benson aclity Name (If not institution, give street and number) 4c. County of Death Anne Arundel Linthicum Chesapeake Hospice House If Under 1 Year If Under 24 Hrs. Months Dava Hours Min. 8. Date of Birth (Month, Dey, Year) 7. Age (in yrs. last birthdey) Birthpleca (State or Foreign Country) Months 1□ M 2√F Yrs. Oct. 29, 1913 85 Md. 219-01-5521 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. Anne Arundel Linthicum 1 Yes 2000 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Waterfountain Way 21061 U.S.A. 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus 1 ☐ Never Memled 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: White f Yes, Give * Yeer or Detes: 3 □ Widowed 4 □ Divorced 18e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementery/Secondery (0-12) College (1-4or 5+) Own Home 6th 17. Father's Name (First, Middle, Last) Housewife 18. Mother's Name (First, Middle, Melden Sumeme) William Beall Elsie Smoot 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addreas (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John Beall / Brother 20a. Method of Disposition 6840 Belclare Rd., Balto., Md. 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 5 - Dete 20c. Location - City or Town, Stete 1 ☐ Burlai 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Balto-Wash. Crematory Laurel, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Kancroatic Conce a stabe Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findinga svallable prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic avant, the Modical Examiner must be nothed at

permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natu any injury or other traumatic avant. me

the Maryland

hours after

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

physician and the burial-transit for use as signed by peed page 2 has certificate To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; t

Physician/Medical þ Completed Be Certification: To

25. Was case reterred to medical 27. Mangfer of Deeth

Medicai

4 Homicide 29a, Cartifler (Check only one)

1 Natural

2 Accident

3 Sulcide

1 Yes 2 No

29b. Signature and title of certil

5 Pending

Investigation

8 Could not be

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Neme and add esson who completed cause of deeth (item 23a) (Type, Print) CHOPRA 7575

31. Date filed (Month, Dey, Year) MAY 1 4 1999

32. Registrar's Signeture

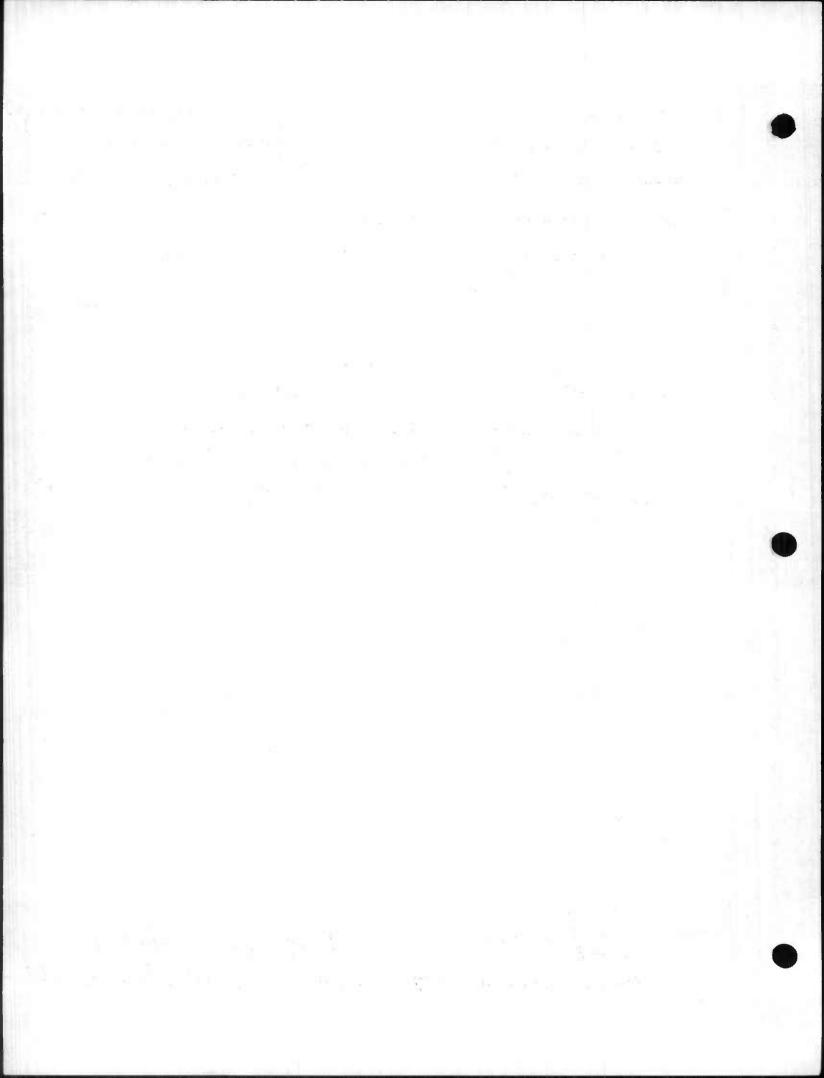
28a. Date of Injury (Month, Dev Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, tarm, street, tectory, offica building, etc. (Specify)

28b. Time of

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM#5 PER F.H. q771 5-14-99 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 6, May Thelma Alverta Bedell 1999 1:40 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Center/Genesis Eldercare

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un Mont Baltimore Dundalk 8. Date of Birth (Month, Day, Year)
Time 12, 1916 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2□ F Md. Director 218-64-2259 82 **Usual Residence of Decedent** 10a. State 10c. City. Town or Location 10b. County 10d, Inside City Limits ne 23a or 28a-f ahor 1 Yes 2 No Dundalk Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH U.S.A. Nerns 23a 21222 2506 Liberty Parkway Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Fages 1 and 2 should be filed within 72 hours effer on the filed within 72 hours effer on the filed within 12 he marked other than Instural; or feeling or other theumatic event, the filed on the feel market of the filed on the 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) 8 Beulah Long John Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2506 Liberty Pkwy, Dundalk, Md. 21222 Phyllis Coffey / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5-8-99 *Burial 2 Cremation 3 Removal from State Department Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park Elkridge, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) lusurin DEPENDENT DIABETES Examiner MELLITUS Examiner ARTERY ORDIVARY The lew requires that the death certificate be executed the buriel-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: P TE N SIBM

Due to (or as a consequence of): Box 68760. Physician/Medical MENTIA P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. ð 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1□ Yes 2□ No funeral 27. Manner of De 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation 1 Dilaturat epital or Attendin nours effer death. nerel Director: Aff 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D completely filled I 11 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

SOM John 31. Date filed (Month, Day, Year Wille 1 4 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

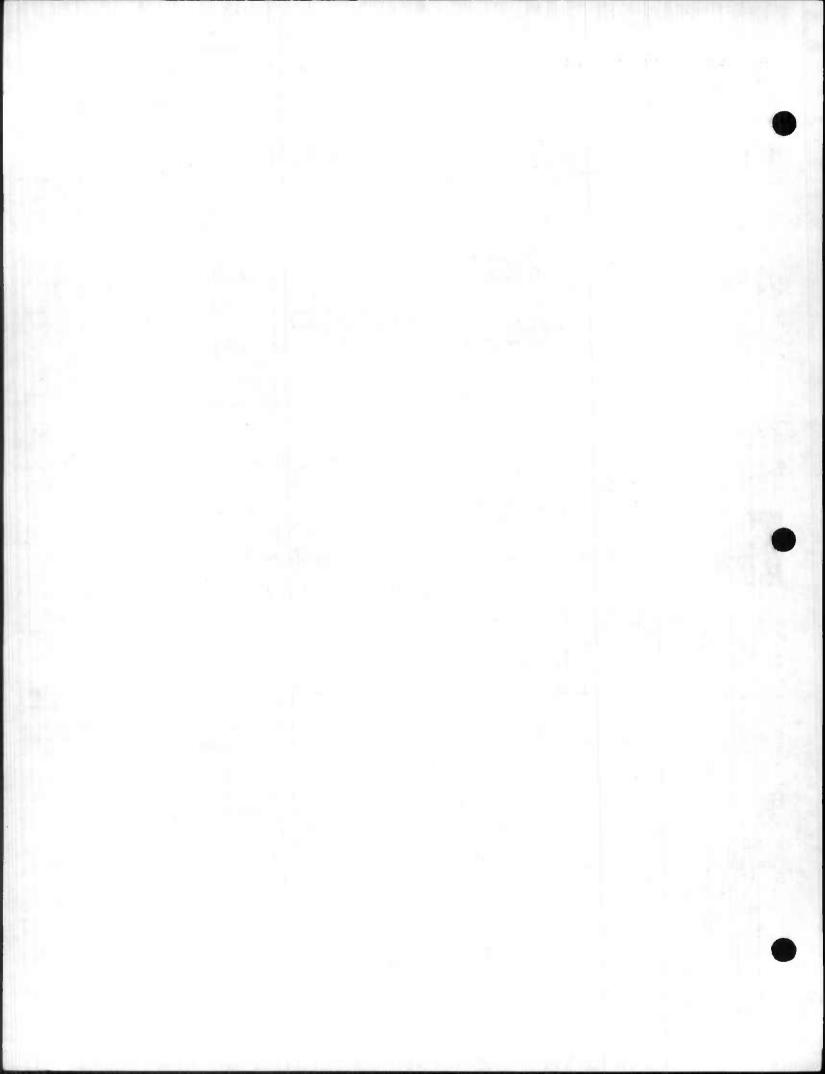
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Ma 32. Registrar's Signature

lace Baltines MD 28222



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 15663 State of Maryland / Department of Health and Mental Hygiene 🖣 🖣 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 4e Facility Neme (If not institution, give street end number) 1999 MAT /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SANDSBURY BALTO. If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yeer) 5. Sociel Security Number If Under 1 Yaar 1. Aga (In yrs. last birthday) 8. Sex Birthplece (Steta or Foreign Country) **Funeral** Deys 1 M 200 F Months 085-07-4068 Yrs. Director Usuel Rasidence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. Inaide City Limits 7 ie marked other than "naturel", or items 23e or 28a-f show treumstic event, the Medical Examinar must be notified at MD 1 Yes 2 No Director BALTO. MULMONI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SANDSBURY 21093 RD U. S.A pamit. Pages 1 end 2 should be filed within 72 hours after death 1 Department of Health end Mentel Hyglene. Important: If item 27 ie marked other than "naturel", or items 23e any Injury or other treumstic event, the Medical Examiner must once. Funeral 14. Race - Amarican Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Bleck, White, etc. 1 ☐ Yes 2 No 1 □ Never Marriad 2 □ Married 1 Yes 2 No Specify: Specify: ò 3 DWIdowed 4 □ Divorced WhiTE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 13 Housewife HOME NIA 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ETTA TYLER B. SUTER MARIS 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Brothers 21093 DEBORAL . L. SANDSbury . P.D. TIMONIUM an 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removal from State 5/15/99 4 ☐ Donetion 5 ☐ Other (Specify) MIDDLE RIVER Hills Cemetery 22. Name and Addrass of Fecility HARTLEY MILLER FUNEFAL HOME CILTO. 7527 HARFORD RD BALTO, MD 21234 21. Signatura of Funerel Service Licensee action Miller 23a. Part1: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Preumonia 1 wot Examiner Due to (or es e consequence of) Examiner melasonti www ician and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial Physician/Medicai Dua to (or as a consequence of): 88 usa 23b. Did tobacco use contribute to the cause of death? ed by the e Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 No 3 Probably 4 Unknown ate hes been signed by page 2 should be detact p 24b. Were eutopsy findings eveilable prior to 24a. Was an autopsy performed? Completed complation of causa of death? 2 NO 1 ☐ Yea 2 ☐ No or Attending Physician: after death. Director: After this certific funeral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Presidence 6 Other (Specify) Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 2 Accident 5 Pending 1 TYes 2 No investigation 6 Could not be determined 3 Sulcida 28e. Plece of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Mospital Funeral 29a. Certifier Tip Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place and place and place and place are the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place and place are the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place are the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place are the cause(a) and mention end/or investigation, in my opinion, deeth occurred at the time, date and place are the cause are t Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as ateted. Medical Within 24 hot At the Fune completely fi (Check only one)

29c. Licensa number

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32. Registrar's Signeture

YLICH EEEE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Dete signed (Month, Day, Year)

State Registrar 29b. Signatura and titla of g

STANCEY WASTE 31. Dete filed (Month, Dey, Year)

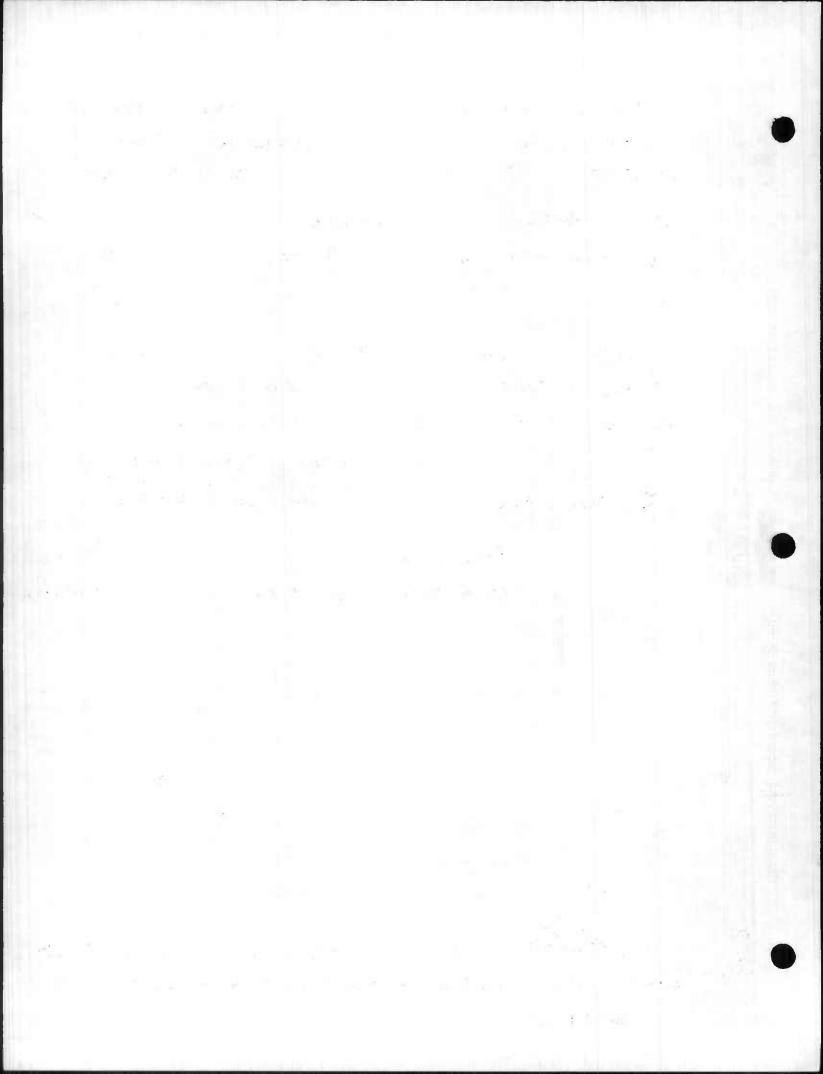
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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.



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Registrar **DHMH 16 Rev 6/95**

State

nth, Day, Year) 32. Registrar's Signature 4 1999

OSC

O.C.M.E.

npleted cause of death (ttem 23a) (Type, Print)

N CSTANGIII Penn Street, Baltimore, Maryland 21201

10, 1999

MAY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Russell Leroy Crum 13, 1999 7:08 pm May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arncliffe Road Essex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Yrs. 59 Director Sept. 26, 1939 217-34-9877 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 20 No Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1024 Arncliffe Road U.S.A. 21221 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ⊠ No If Yes, Give Yeer or Dates: 14. Raca - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 1 No Specify: White Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10 Can Manufacturer Die Setter 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth M. Crum Geraldine Whiplle 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Crum (wife) 851 Sue Grove Road, Baltimore, Maryland 21221 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or phose. Holly Hill Mem. Gardens 5/17/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenti Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert tailure. List only one cause on each line. Approximate tntervel Between Onset and Death **Physician** VENTRICULAR ARRYTHMIM /Medical Immediata Causa (Final disease or condition resulting in death) Examiner CORONARY ARTERY DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION þ 24a. Was an autopsy performed? Completed EMPHYSEMA 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpetient 2 | ER/Outpatlent 3 | DOA Other: 4 Nursing Home \$ Residence 6 Other (Specify) Certification: To 1 Yes 2√ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 KNaturel 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

physician end the burial-transit Box 68760 certificata

the Maryland

72 hours after

Baitimore, Maryland 21215-0020

from 23a or 28a-f show

the Medical Examiner

Pages 1 and 2 should be filed within nent of Haalth and Mental Hygiene. Int: If Item 27 is marked other than "I ury or other traumatic event, it is it is

edical

29a. Certifie

(Check only one)

P.O. Division of Vital Records, ... of Vital
... nospital or Attending Physician: Th.
Yin 24 hours after death.
Ye Funeral Director: After this After this After this After this After this After this After this After this After this After this After this

State Registrar DHMH 16 Rev 6/95

To the F within 2

29b. Signeture and title of cartifier

29c. License number 022620 29d. Dete signed (Month, Day, Year)

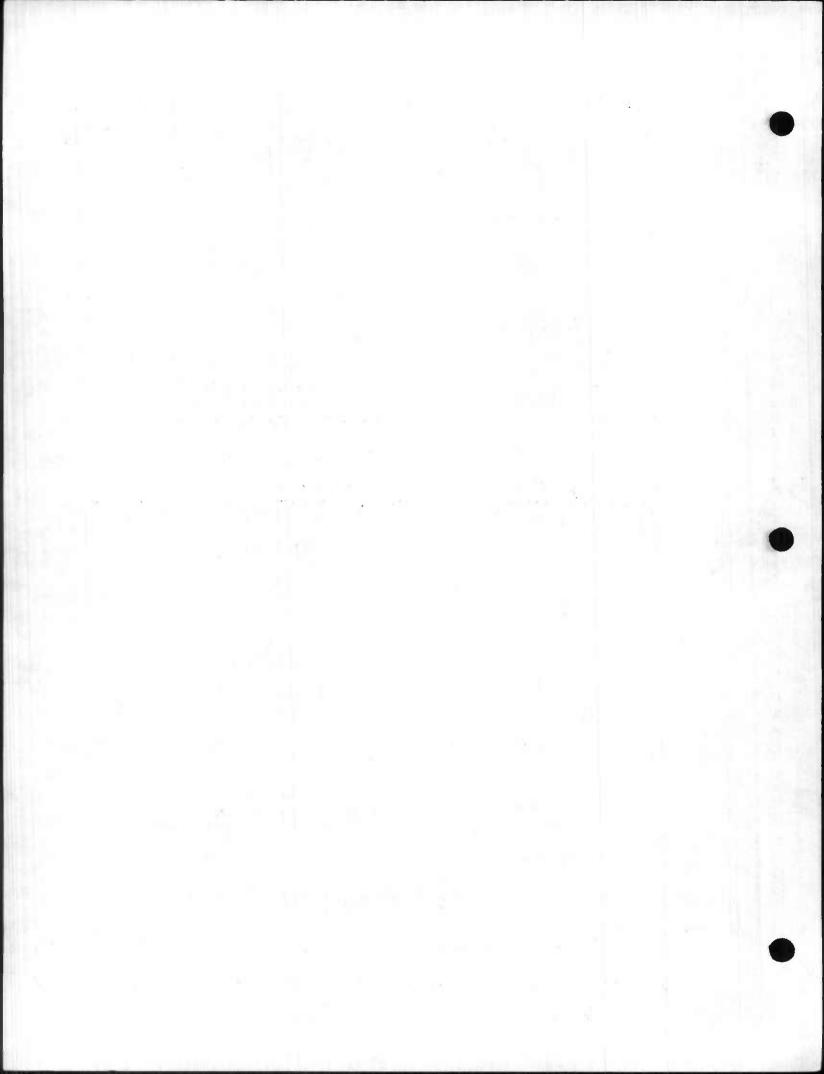
30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

6830 HOSPITAL DR. BALT. MD 21237 SHAHID SAEED MO

🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

31. Date tiled (Month, Day, Year) MAY 14

32. Registrar's Signature

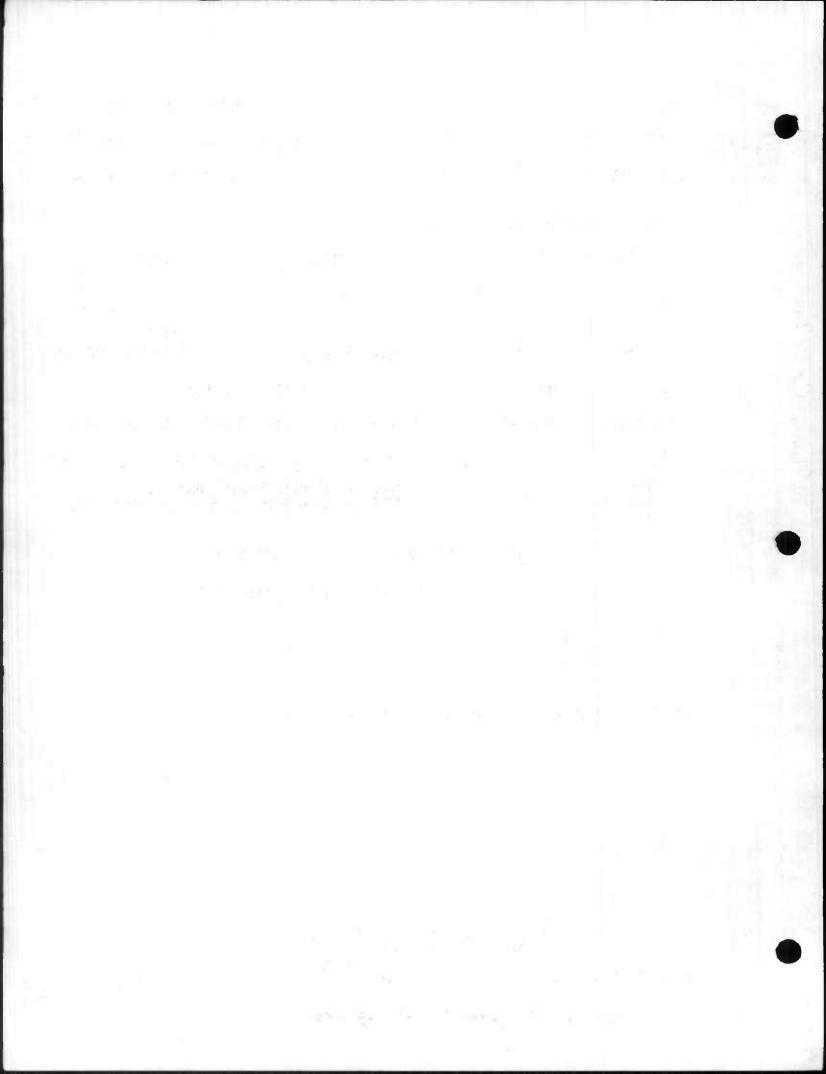


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Lest) 2. Date of Death **Physician** 11-30 Pm 13 1999 Mary A. Cadden /Medical 4a. Facility Name (If not institution, give street and number)
NORTH PRUNDEL HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnine Anne Arundel Co 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yaar) Birthplace (Stete or Foreign Country) **Funeral** 1□ M 2**X** F Days 63 Yrs. Director 213-32-7188 Oct. 23, 1935 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-t show must be notified at Director 1 ☐ Yes 2 No Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Наста 23а 212 Chelsea Road Funeral 21122 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No
If Yes, Give
Year or Dates: "natural", or 1 ☐ Yes 2 ☐ No by 3 ☐ Widowed 4 ☐ Divorcad Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Allstate Elementary/Secondary (0-12) Collage (1-4or 5+) Insurance Company 12th Office Manager important: if Itam 27 is marked other any injury or other traumatic event, if once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) and Mental James Falter Adele Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Haalth Tina Jenkins (Daughter) 11009 Wood Elves Way Columbia, Maryland 21044 20a. Mathod of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stata 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 5/17/99 Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arras shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Death **Physician** /Medical PULMONARY Immediate Cause (Final EMROLISM disease or condition resulting in death) Examiner Physician/Medical Examiner DE THE LUNG that the death cartificete be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaase or Injury that initiated avants resulting In daath) Last Box 68760, tha Due to (or as a consequence of): P.0. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No PLEURAL EFFUSION Records, ρ Be Completed 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 2 No cartificate 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Diractor: After this cartifica completaly filled in by the funaral director; p 25. Was case referred to medical axaminer? 26. Placa of Death (Check only one) Hospital: 1 patient 2 ER/Outpatienf 3 DOA 1 Yes 2N No Othar: 4 Nursing Homa 5 Residanca 6 Other (Specify) Certification: To 27. Manner of Daath 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending Investigation 1 Natural 2 Accident 1 Yas 2 No 3 Suicide 6 ☐ Could not be detarmined 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homleida edlcai 29a. Certifier Certifying Physicien: To the best of my knowledga, daath occurred at tha time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only License number 29b. Signature and fitle of certifier 29d. Date signed (Month, Dey, Year) D51664 30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print) 5 VD HTR KVMM AGGARNAL NORTH ARUNDEL HOS PITAL, 301 HOS PITAL OR IYE, GLEN BURNIE, MD 21061 State Registrar



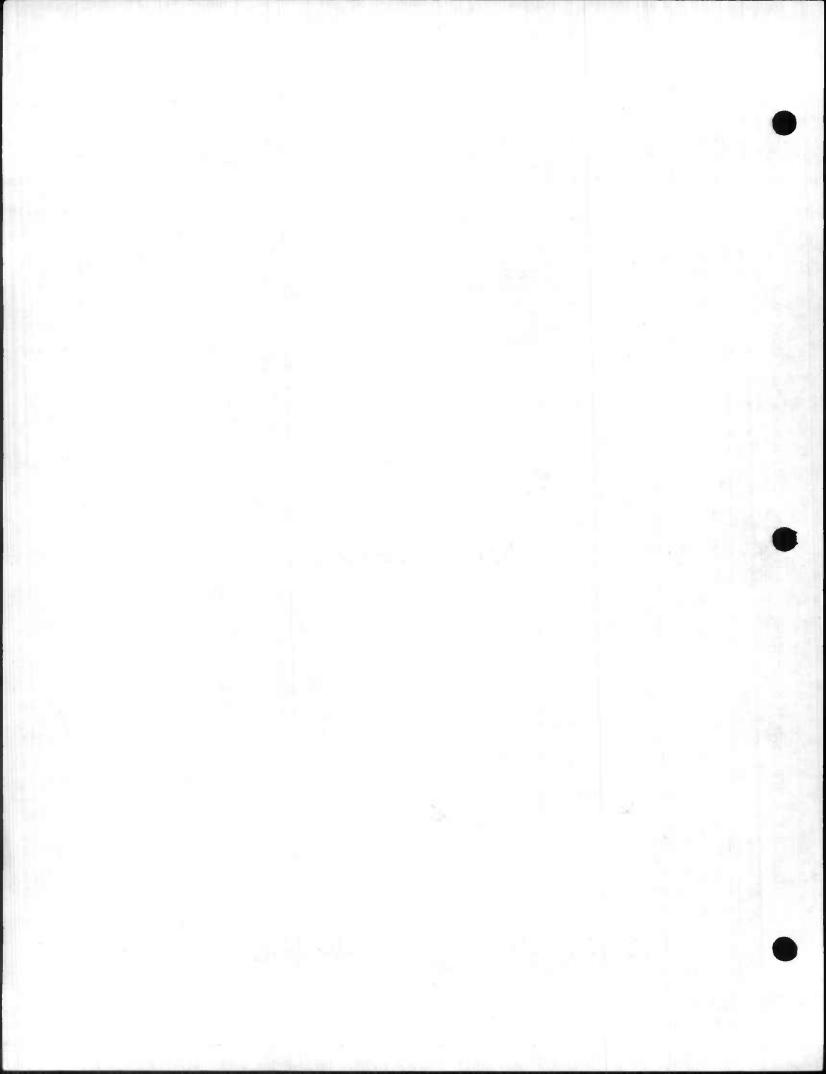
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

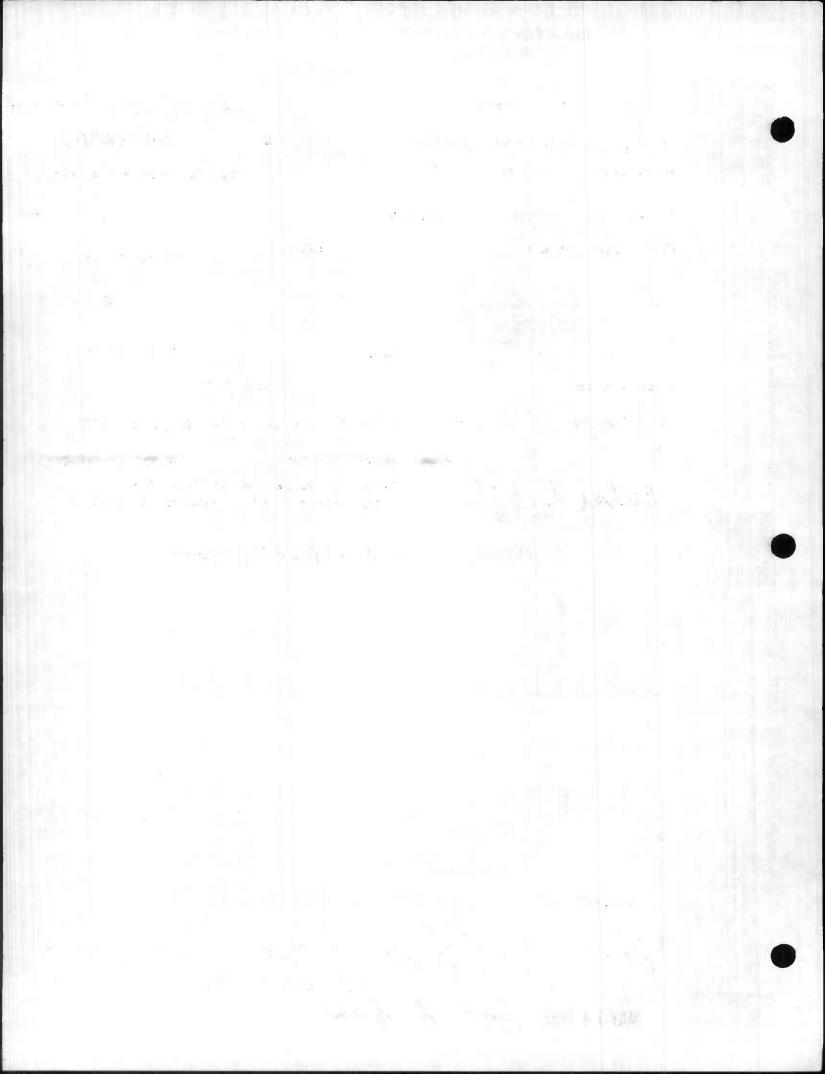
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	Decedent's Name (First, Middle, Last)	2. Dete of D Month		3. Tima of Deeth					
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niner	la Facility Name (If not institution, give street and number) 4b. City, To	wn, or Location of Dea	ith 4c. County of [
	Greater Baltimore Medical Center Tows	on	Balti	imore					
Ī	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours	24 Hrs. 8. Dete of B (Month, D	irth 9.	Birthplace (State or Foreig Country)					
	212-40-5936 1 M 2 F 94 Yrs. Months Days Hours Usual Residence of Decedent	Sept 1		Maryland					
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
-	Maryland Baltimore Timonium			1 ☐ Yas 2 🎇 No					
DISCIO	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	t Country?					
2	10 Harding Street 21093		USA						
	11. Marital Status 12. Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Ori	gin? (Specify Yes or N		American Indian,					
1	1 Never Married 2 Married 1 Yes 2 No			White, etc.					
	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify:	White					
	15. Decedent's Education 16a. Decedent's Usuel Occupation	e of the differen	16b. Kind of Busine	ess/Industry					
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during mos life. DO NOT use retired)	t of working							
	10 n/a Assistant to Jury Co	ommissione	r Baltimor	e County Gov					
,	17. Father's Name (First, Middle, Last) 18. Mother	er'a Name (First, Middle	e, Maiden Surname)						
	William Franklin Shoul E	lsie	Mar	ble					
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	er or Rural Route Num	ber, City or Town, Sta	te, Zip Code)					
	Rita C. Oehrl/Daughter 4 West Main Blvd	d. Timoniu	um, Maryla	nd 21093					
	20b. Place of Disposition (Name of	Dete	20c. Location - City						
	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1 ☑ Burial 2 ☐ Cremetory or other plece) 1 ☑ Burial 2 ☐ Cremetory or other plece)	- 15/1//00	Tri	. Manualana					
	4 Donation 5 Other (Specify) Dulaney Valley Mem. Grd 21. Stratup of Funeral Service Lighter 22. Name and Address of Facility		TIMONIUM	m, Maryland					
	Lemmon Funeral	*							
	Bryan W. Clary 10 W. Padonia	road, Timo	nium, MD	21093					
	23a. Part1. Enfor the disease, or complications that paused the deeth. Do not enter the mode of dying, such es shock, or heart salure. List only one cause on each line.	cardiac or respiretory	errest,	Approximete Intervel Between					
Examiner	Due to (or es a consequence of): b								
edical EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):	Due to (or es a consequence of):							
Physician/Med	d								
5	Part II. Other significant annulation and the same state of the sa	1 con Die	44-4						
-	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		. Did tobacco use contributa to the causa of dear 1 Yes 2 No 3 Probably 4 White						
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Completed			s en eutopsy 2 formed?	4b. Were eutopsy findings eveilable prior to					
1		_	completion of death?						
		1□	Yes 21 No	1 ☐ Yes 2X No					
0	25. Was case referred to medicat 28. Place	of Deeth (Check only	one)						
	axaminer? 1 Yes 2 No Hospital: 1 Inpatient 2 FWOutpatient 3 DOA Other: 4 Nu	rsing Home 5 Res	sidence 6 Other (Specify)					
	77. Manner of Death 28a. Date of thiury 28b. Time of 28c. Injury at Work?	28d. Describe	how injury occurred						
	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2	No							
	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location City or To	281. Location (Street and Number or Rural Route Number, City or Town, Stete)						
10000	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, dea	d place, end due to the	e cause(s) end menne	er as stated. due to the cause(s)					
20	one) and manner stated.								
	29b. Signature and little of centifier 29c. License number		29d. Dete signed (A	nonth, Dey, Year)					
	onuxum) D4ZA	10	May 13	3, 1999					
	0. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-						
	Susan Meltzer, MD 12221 Tullamore Road, Timonium	, MD 2109	3						
e	11. Date filed (Month, Day, Year) 32. Registrar's Signeture								
rar	MAY 1 / 1000								



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Death **Physician** 0615 Lillian G. Commons AM MAY 4c. County of Death /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) Examiner PEACH TREE BOWLE PRINCE GEORGES LANE If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 M 2 F 166 34 7049 88 Yrs. Director Nov. 18, 1910 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haatth and Mental Hygiena int: If Item 27 is marked other than "natural, or items 23s or 28s-f show my or other traumatic event, me Medical Examinating notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pennsylvania Cambria 1 ☐ Yes 2 ₩ No Nanty Glo Director 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 1197 Roberts Street 15943 United States Funeral Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Ongin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify g 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondery (0-12) College (1-4or 5+) 12 Nurse State School 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Sally Kerr James Leonard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Anita Zamboni Daughter 1734 Peachtree Lane Bowie Maryland 20721 20b. Place of Disposition (Nama of cemetery, crematory or other place) May 15, 1999 20c. Location - City or Town, State 20s. Method of Disposition Department of important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) The Fairview Cemetery Patton Pennsylvania 21. Signature of Funeral Service Licensas 22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medicai Immediate Cause (Final disease or condition resulting in death) . ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or es a consequenca of): Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physiclan/Medicai Due to (or as a consequence of) 50 980 ō signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probabty 4 Unknown 1 Yes 2 No Division of Vital Records, þ 24b. Were autopsy findings available prior to 24e. Was en eutopsy performed? Completed completion of cause of deeth? icartificata has b 2 No 1 ☐ Yes 2 ☐ No director, or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Dother (Specify) DAUQ https: 1 Yes 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Date of tnjury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Home After 1 Netural s after deen. al Director: After hv the fi 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di letely filled in Hospital 29a. Certifier 1 __Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner as stated. Medical To the Fune completely f (Check only one) Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and mannar states. To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) DME 30. With and address of person who comp tod ceuse of death (ttem 23a) (Type, Print) HOSPITAL DRIVE, CHEVERLY, GOLVE MARIO F-31. Dete fited (Month, Day, Year) State

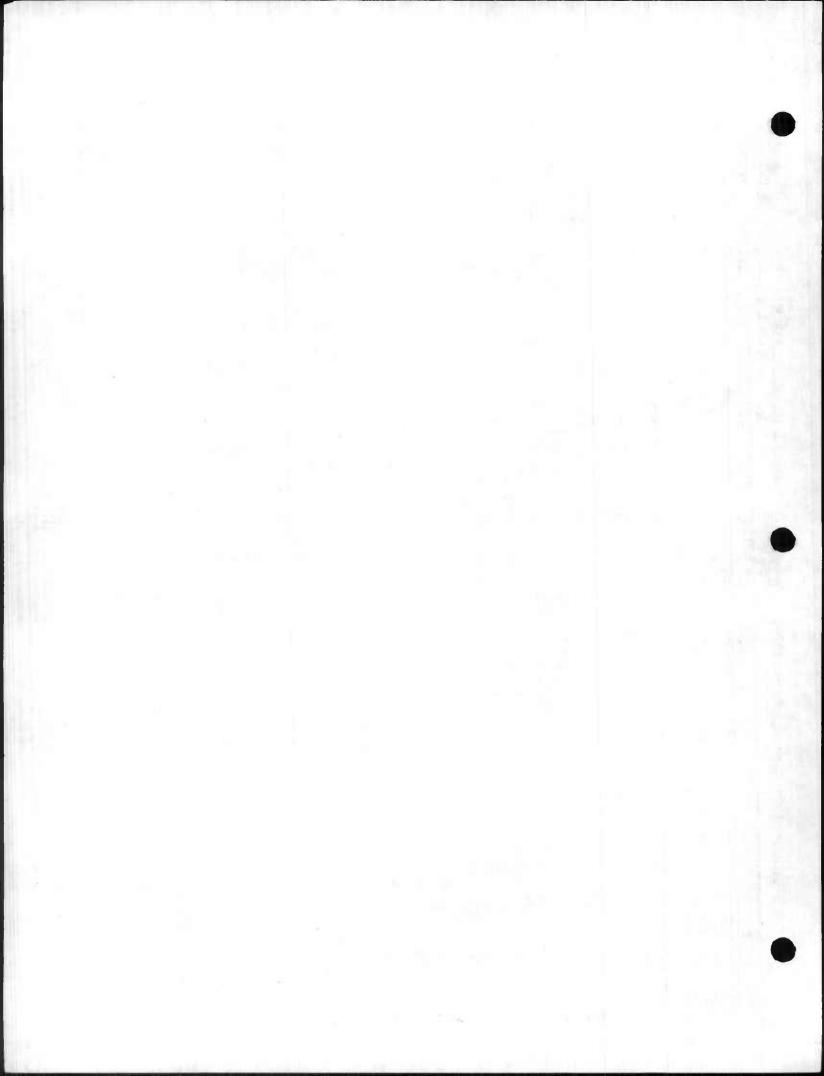
Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 15669

					Certif	ficate of	Death		Reg	ı. No.			
		1. Decedent's Neme (First, Middle, La	st)						2. Date of Death			3. Time of Death	
Physi		TROY A.	COHEN						Month MAY 11	Day 199	Year G	0552 AM	
/Med Exam	dical niner	4e Fecility Neme (If not Institution, giv 4009 WILLSBY AVE						rwn, or Loc	ation of Death	4c. Count	y of Death		
Funera Directo		5. Sociel Security Number 6. S 216-90-0446		(tn yrs. last bir 21		Under 1 Year Ionths Days		Min,	8. Dete of Birth (Month, Day,) JUNE 27		9. Birthp Coun	**	
pue *		10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Lim											
death with the Maryland ms 23s or 28s-f show r must be notified at	Director	MARYLAND N/A	BALTIMORE 10f. Zip Code						100	1 √Yes 2 No			
ath with		4009 WILSBY	1218			U.:	U.S.A.						
21215-0020 d within 72 hours after death with the Manylan glene. If then "naturel", or flems 23s or 28s-f show it to be notified.	by Funeral	11, Meritel Stetus 11/2 Never Merried 2 Merried 3 Widowed 4 Divorced	er in U,S.	If Ye	s Decedent of es, specify Cut	an, Mexicar	n, Puerto F	rto Rican, etc.) Black, Wh			merican findian, hite, etc. RO-AMERICAN		
72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a.	(Give kind	r's Usuel Occu d of work done	during mos	t of workin	10	Sb. Kind of B	usiness/Inc	dustry	
	id id	Elementary/Secondery (0-12)	College (1-4or 5+)			NOT use retire				DI IN CO	T110		
N DD	ပိ	9th 17. Father's Neme (First, Middle, Last)	N/A	AP.	PREMI	CICE PL		er's Name	(First, Middle, Me	PLUMB.			
A Anylicano Sand Mer	o Be	HOLBROOK COHEN									,		
		19e. Informent's Neme/Reletionship (Type, Print)	19b	o. Meiling A	Address (Stree	t and Numbe	er or Rural	Route Number,	City or Town	State, Zip	Code)	
		HOLBROOK COHEN,	JR./ FATHE	R 2	236	W. LE	XINGTO	N ST	BALTO.	MD	212	23	
Baltimore, Normali. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		20e. Method of Disposition / 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete											
Pages ment of it		1 Burial 2 Cremetion 3 Demoved from State Condition 5 Other (Specify) 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify)											
Balti permit. Departm imports eny inju	DUC.	21. Signature of Funeral Service Licansee CALVIN B. SCRUGGS FUNERAL HOME											
W &0.5 8	a	1412 E. PRESTON ST. BALTO MD. 21213											
-		23a. Pert1. Enter the diseese, or comp shock, or heert feilure. List only	olications thet caused the	e deem. Do i		he mode of dy	ing, such es	cardiac or	respiretory arres	it,	- Copt o	Approximete Intervel Between	
Physician												Onset end Death	
/Medica Examine		Immediete Cause (Final diseese or condition	a. Gunst	not u	veun	d of	the	h	ead		1		
Lazaninie	100	resulting in death)		ue to (or as e							1		
bed is	- lu		b								-1		
BOX 68760, set certificate be associted attending physician and for use as the bunal-transit	edical Examiner	Sequentially list conditions, if any, leeding to immediate	Du	e to (or es e	consequen	nce of):							
68760 ficate be a physician is the buris	cal	Cause, Enter Underlying Cause (Disease or Injury Cause (Disease or Inju											
68 ilicate g phy as the	Pa	resulting in deeth) Last	Du	e to (or es a o	consequen	ice of):					1		
BOX sath cert attending for use	In/M		d										
death death	sicia	Part II. Other significant conditions of	ontributing to death but r	not resulting in	n the under	riving cause gi	ven in Pert I	1.	23b. Did tobacco use contribute to the cause				
es that the death ce igned by the attend be detached for us.	hys	•				,g cauco g			1 Yes 2 No 3 Probably 4 Unknow				
S, F ss tha	by F							_					
v requir	Completed by Physician/								24a. Wes an performe		80	ere autopsy findings allable prior to impletion of cause death?	
Of VITAL Re- Physician: The lav this certificate has ral director, page 2	E								1 DYes	2 🗆 No	LE	∰Yes 2□ No	
Tan	Be	25. Was case referred to medical					26. Place	of Deeth	(Check only one,)	1	1	
yelc dire	To	axeminer? 1XXes 2□ No	Hospitel: 1 ☐ Inpatient	2 ER/Ou	utpatient :	3 DOA O	her: 4 Nu	ursing Hom	ne 5 Residen	ce 6 Oti	her (Specif	y)	
Ter the residence of th	ü	27. Menner of Death 1 □ Neturel 5 □ Pending	28a. Dete of Injury (Month, Dey Y	(ear) 28b. 1	Time of Injury	28c. Inju	ny at irk?	2	8d. Describe how	injury occu	rred		
DIVISION Of VITA of or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification:	2 ☐ Accident investigation	0 11 7	9 unt	Thown	M 1	Yes 2 🔀	No	Subject	was	5 5 h	ot	
or An in by	E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Injury building, etc. (Specify)				2	 Location (Streetly or Town, 	State) 46	ber or Rura	al Route Number,	
DIVI		00.00.7			iden				saltimore	Cit,	Y, M	anyland	
To the Hospital summing the Funeral completely tilled	edical	29e. Certifier (Check only one) 1 Certifying Physical Example Control one)	sician: To the best of n	caminetion en	e, deeth oco id/or investi	curred at the ti ligation, in my	me, date an opinion, dee	d place, and th occurre	nd due to the cau d at the time, dat	se(s) end m e and place,	enner as s	lated. the cause(s)	
of the state of th	Me	29b. Signeture end title of certifier	end manner stete	0.		29c. Licen	se number		290	d. Date signe	ed (Month.	Dav. Year)	
- 17 8	1	AT 1.	1 11	11-			C.M.E.	•			12, 1		
19	1/	30. Neme end address of person who	n V La	CVJ	LMD								
20	/						Baltir	nore,	Marylar	d 212	01		
S	tate	31. Dete filed (Month, Day, Year)	32. Registrar's						-				
Regis		MAY 1 4		neva	B.	100	cks/						



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State of Maryland / Department of Health and Mental Hygiene 99 15670

			Cer	tificate of	Death		Re	g. No.			
	1. Decedent's Name (First, Middle, Li	ist)				2	2. Date of Death	h		3. Time of Death	
Physician (Madisal	Ruth Fletcher	Clardy				1	Month May 12,	Day 199	Year 39	2:00am	
/Medical Examiner	4a Facility Neme (If not institution, gir				4b. City, To		ation of Death	4c. County		Z. OOdii	
	517 Jo Ann Driv	e		4	Odent	ton		Anne A	Arund	el	
Funeral Director		Sex 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. g	8. Date of Birth (Month, Day, Year) June 27,1923 9. Birthplace (State or F Country) Maine				
8 .	Usuel Residence of Decedent 10a. State 10b. County	100 0%	y, Town or Loc	etion					Te	Od Incide City I local	
shyta show show	MD Anne Ar		denton	ation					"	od. Inside City Limit 1 ☐ Yes 2 💢 N	
or 28a-fs be notified Director		under 0	dencon								
	10e. Street and Number 517 Jo Ann Driv	e		10f. Zip Code 211	13		10	og. Citizen of V USA	Vhat Coun	try?	
Uzo ura after af, or ha Examina by Fur	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cut ☐ Yes 2000			ify Yes or No- ican, etc.)	Blac	e - America ck, Whita, a r: Whi	NC.	
ad within 72 ho ad within 72 ho ygjens, er than 'natur it, the Medical. Completed	15. Decedent's E	ducation	16a. Deced	ent's Usual Occu	pation	t of working	1	6b. Kind of Bu	siness/Ind	lustry	
within one. the Mes	Elamentary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)		e or working						
filled w Hygier ther th	12	3	Teach	ner				Educati			
Be state a	17. Father's Neme (First, Middle, Last)					First, Middle, M	faiden Sumam	ie)		
Mental Me	George Fletcher Grace										
2 she 2 she is ma	19a. Informant's Name/Relationship			g Addrass (Stree					Stata, Zip	Code)	
	Wayne T. Clardy		1	o Ann D	rive,	Odent					
omit. Pages 1 ar Separtment of Hea reportant: if Item? rey Injury or other Rice.	20a. Method of Disposition 1 □ Burial 2 ZaCremation 3 □ 4 □ Donetion 5 □ Other (Speci	Removel from State	ematary, crem	ition (Name of latory or other pla ematory	ice)	05		80c. Location - Baltimo			
Demit. Departm Departm Importa any inju	21. Signature of Fineral Service Licensee 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401										
	23a. Part1. Enter the disease, or copy shock, or heart failure. List only	Dications that caused the death							401	Approximate	
Medical Examiner parameter production and productio	Immediate Cause (Final disease or condition resulting in death)	a. Lung Emp	(and as a consequence of the con	pence of):							
ng physicla as the bur	Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last	c. Due to (or	r as a consequ							Jai	
attending for use		d							1		
the all	Part It. Other significant conditions	contributing to death but not rest	resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of d				
res that the death or signed by the attend for us Ibe detached for us Iby Physician/	Parkinso.	n's Disc	aje				1×1	s 2□ No	3 Prot	ebly 4 Unkno	
aw requi							24a. Was ar perform		ava coi	ore autopsy findings allable prior to inpletion of cause death?	
The la sate he page							1□ Ye	s 2 No	10	Yes 25 No	
delan: The certificata rector, pag	25. Was casa referred to medical				26. Place	of Death (Check only one	9)	1		
Physician: this certificial director.	examiner? 1 Yes 2 No	Hospital:	ER/Outpatient	3 DOA OI	her: 4 Nu	rsing Home	a 5) Reside	nce 6 Oth	ar (Specif)	0	
After funa	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28	d. Describe ho			,	
To the Hospital or Attending P within 24 hours after death: within 24 hours after death: completely filled in by the funers Medical Certification:	3 Suicide 6 Could not to determined	28e. Ptaca of Injury - At he building, etc. (Specify						if. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 112 Certifying Ph (Check only one) 2 Medicat Example 1	nysictan: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death tion and/or inve	occurred at the ti estigation, in my	me, date an opinion, dea	d place, an	d due to the ca	use(s) and ma ita and place,	nner as st and due to	ated. the cause(s)	
within To the compl	29b. Signature and title of certifier			29c. Licen	se number		29	d. Date signe	d (Month,	Day, Year)	
PSFO	D-MI	Therie -	,	DY	175	18		5-17	99	9	
	30/ Name and address of person who	completed causa of death (item		rint) tve. Stel	2.	1004	enly h	no 7	175	(
							70.17		~ ~ ~	1	
State Registrar	31. Date filed (Month, Day, Year) MAY 14 1999	Demin	P. A	parks							

when the married to be the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Marbury L. Councell, III May 4:18 A.M 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Square Hospital enter | osedale 5. Social Security Number Baltimore if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) 219-50-4591 18 M 2□ F Months Days 50 19,1948 Maryland August Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10962 Shadow Lane 21044 U.S.A. 14. Raca - American Indian. 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Computer Furniture College (1-4or 5+) Elementary/Secondary (0-12) Owner/President Company 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Margaret Day Marbury L. Councell, Jr. 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10962 Shadow Lane, Columbia, MD 21044 Marianne Councell (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriat 2 Cremation 3 Removal from Stata Columbia Memorial Park 5/15/99 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one causa on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Current Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of) 23b, Did tobacco use contributs to the ceuse of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signatura and title of certifier 29c License number 29d. Data signed (Month, Day, Year)

Registrar DHMH 16 Rev 6/95

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

the Maryland

MaRBURY

ouncell,

Pages 1 end 2 should be filed within 72 hours after death with the Marylan ment of Health end Mental Hygiene. snt: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, tra Medical Examines round to notified as

Important: If Item 27 is any injury or other tra pace.

Physician /Medical

Examiner

physician and the buriel-transit

attending for use as

signed by the all d be datached for

should should

his certificate hes b al director, page 2 s

funeral

by tha f

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

31. Date filed (Month, Day, Year) State

DrSavitha

1999

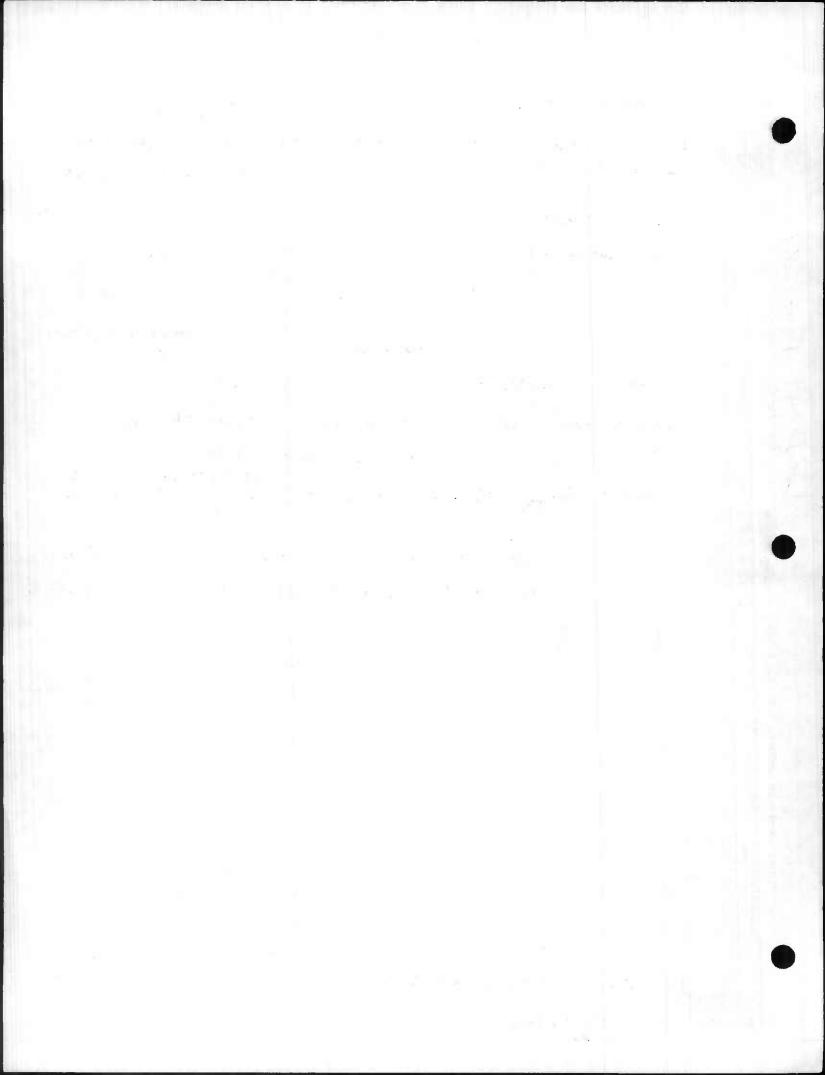
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Vananda



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9000 Franklin Square Drive Baltimore, Maryland 21237



or Print in Black Indelible Ink Assure All Conles Are Legible

9-2/20-5.10	Please Type of Phill in Black indelible link. Assu
DANIEL	State of Maryland / Department of Health a
CER BATCHESI	Certificate of Death

DA	NIEL MMISKEY		110	State	of Maryland	d / Depa		of H	lealth a	and M		giene Reg. No.	99	15	672
	Physician /Medical		it's Name (First, Mid DANIEL		MMISKEY						2. Date of Dec Month MAY	ath Day	Year 1999		me of Death 10P.M.
	Examiner		Neme (If not institut NES HOSPI	ion, give street and n	umber)			4	BALT		cation of Death	4c. Cour	ity of Death		
	Funeral Director	221-	24–6110	6. Sex 1727 M 2□ F	7. Age (In yrs. li	ast birthday) 57 Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 8/14/	, Year) 1941			itete or Foreign VANIA
	Maryland -f ahow fied at tor	10s. State	dence of Decedent 10b. Coun	ALTIMORE	10c. City	, Town or Lo	ocation	CAT	ONSV.	ILLE			1		ide City Limits Yes 2 No
	h with the Ma. 23a or 28a-f a at be notified		10e. Street and Number 6302 ROWE COURT							8		10g. Citizen o	f What Cour		
020 uns effect des	72 hours efter death with the Maryland natural; or frems 23s or 28s-f show deal Essering must be modified at sted by Funeral Director	3 □ Wid	Status rer Merried 2/15/Ma lowed 4 □ Divorce	cedent Ever in U,S Forces? 2 No iive Dates:	in U.S. 13. Wes Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri						ocity Yes or No- Rican, etc.) 14. Race - American Ind Black, White, etc. Specify: WHIT				
21215-0020	yiene.	Elemente	15. Decede (Specify only high try/Secondary (0-12)	(1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired) SOCIA:						Business/Industry L SECURITY JUSTRATION				
Maryland	A SA SA SA SA SA SA SA SA SA SA SA SA SA	17. Fathers	Neme (First, Middle MICHAEL C	HARLES CU	MMISKEY				18. Mothe	er's Name AULIN	(First, Middle, IE (JE	Maiden Sum LLISON			
	alth and 2 shalth and 27 is m	19a. Informent's Neme/Reletionship (Type, Print) OLGA CUMMISKEY (WIFE) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6302 ROWE COURT CATONSVILLE, MD 21228													
Baitimore,	mit. Pages 1 an partment of Heal portunt: if item 2 y injury or other	to Burial 2 ☐ Cremation 3 ☐ Removel from State					Place of Disposition (Name of cametery, cremetory or other place) ST. JOSEPH'S CEMETERY Date 20c. Location - City or Town, State 5/17/99 CORAOPOLIS, PA								
Ball	Departri Departri Importa any inji	21. Signature of Funeral Service University 22. Name and Address of Facility WITZKE FUNERAL HOMES, 1630 EDMONDSON AVE CATONSVILLE, MD										C.			
-4	Physician /Medical Examiner	Immediate disease or resulting in	Cause (Finel	or complications that st only one cause on a.	ero sclero;		ardio							Interve	ximate el Between and Deeth
	80 5 5 5 E	Cause (Dis that initiate resulting in	y list conditions, ing to immediate er Underlying ease or injury d events death) Last	6		es a conseq									
Ö	the set	Part II. Othe	or algnificant condit	lons contributing to	death but not resu	lting in the u	ndarlying ca	use giv	en in Pert I			obacco use o			use of death?
cords, F	w requires that been signed b should be dete										24a. Wes	an autopsy med?	24b. W	ere auto	opsy findings

Division of Vital Re To the Hospital or Attending Physicien: The les within & Hours after death.

To the Funeral Director Call the this certificate has completely filled in by the funeral director, page 2 Be Com Medical Certification: To

ngs

10 Yes 2 No

MAY 12,1999

Yes 2 No

25. Was case referred to medical examiner?
1 No 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA

27. Manger of Death 1 Anatural 2 Accident 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No

6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) U. Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mennar stated.

29d. Date signed (Month, Day, Year) 29b. Signeture and The of certified 29c. License number

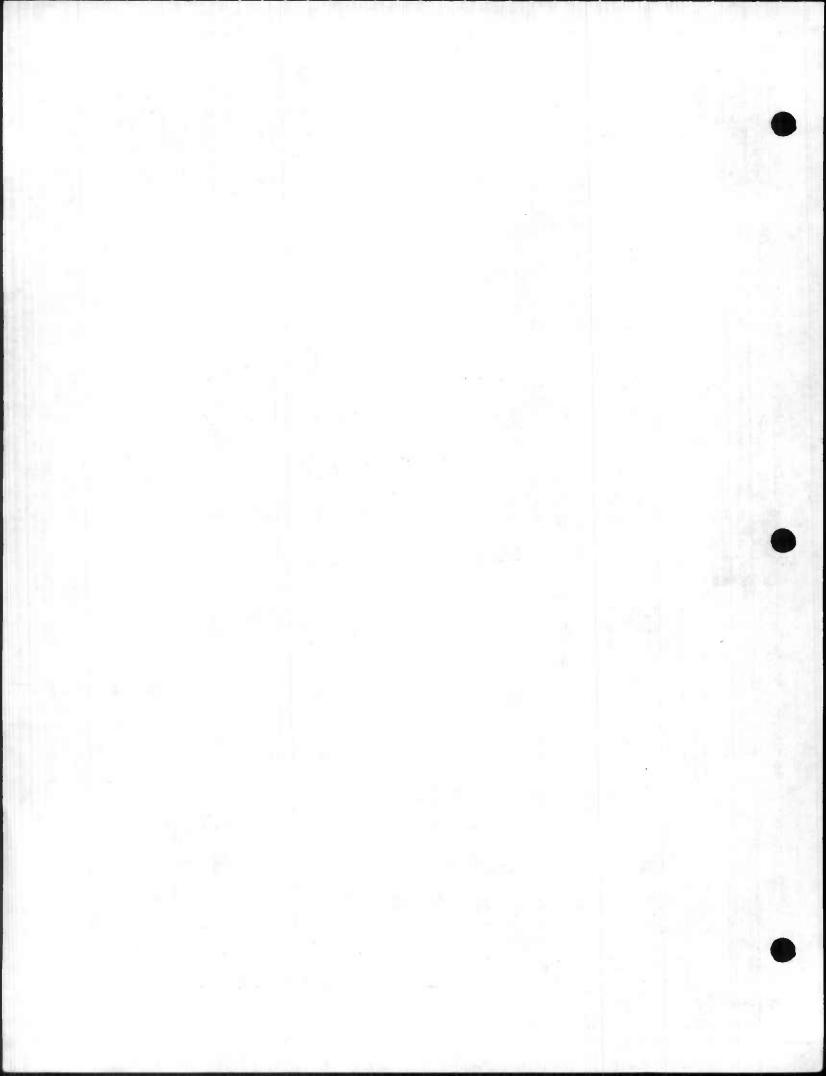
30. Name and addrass of person who impleted causa of death (Item 23a) (Type, Print)

Dennis 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

O.C.M.E.

State Registrar

32. Registrer's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Months

10f. Zip Code

d

Deys

* * * * * * * * * * * * * * * * * * * *	Department of Health and		15673
G771 5-24-99 WR.	Certificate of Death	Reg. No.	10010

Physicia	n
/Medica	ı
Examine	r

1. Decedent's Name (First, Mit/dle, Last) 4e Facility Neme (If not institution, give street and number) 2. Date of Death

4b. City, Town, or Location of Death

BALTIMORE

Manth

3. Time of Death

10d. Inside City Limits

7:56 PM.

Funeral Director

items 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiere. Important: If flem 27 is marked other than "natural", or itema 23a and injury or other treumatic event, the market

Examples must be notified at

Funeral Director

P

Completed

8

0

with the Meryland

Social Security Number 10 M 20 F Usual Residence of Decedent

HARBOR HOSPITAL

10c, City, Town or Location

7. Age (In yrs, last birthday)

If Under 24 Hrs. If Under 1 Year Hours

9. Birthplace (State or Foreign

1 Yes 2 □ No 10g. Citizen of What Country?

10e. Stre et and Number

11. Meritel Stetus 21 Merried

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

Race - American Indian, Bleck, White, etc. 14. Race -Specify:

4215

1 Never Merried 3 Widowed 4 Divorced

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)

16b. Kind of Business/Industry

Maiden_Sumeme)

Dey 1998ear

4c. County of Death

07,

12th

17. Father's Neme (First, Middle, Last) ar te

18. Mother's Name (First, Middle, Meiling Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code)

19e. Informent's Nema/Reletionship (Type, Print) Carter nita 20e. Method of Disposition

Leonard d 20b. Plece of Disposition (Name of Date 20c. Location - City or Town, Stete cemetery, cremetory

3 Removel from Stete 1 Buriel 2 Cremetion 4 ☐ Donation 5 Other (Specify) 21. Signeture of Euperal Service Licenses

10 22. Neme and Address of Fed

23a, Part1. Ert or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Intervet Between Onset and Death

Physician /Medical Examiner

physician s the burial

cate has been signed by the a pege 2 should be detached?

certificate

this

After

death.

24 hours after deat Punerel Director:

within 2 To the

Hospital

funeral director,

filled in by

completely

88 USB

The lew requires that the death certificate be executed

Box 68760,

P.O.

Records.

Division of Vital or Attending Physicien: Physician/Medical Examine

à

Be Completed

Medical Certification: To

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es a consequence of):

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last

Immediate Ceuse (Finel

disease or condition resulting in death)

Due to (or es e consequence of):

Due to (or es e consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Inpatient

23b. Did tobacco use contribute to the cause of death?

RENAL CELL CARCINOMA

1 Yes 2K No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1X Yes 2 □ No

26. Place of Deeth (Check only one)

18 Yes 2 No

25. Wes case referred to medical 1 □XYes 2 □ No

5 Pending investigation

Hospital:

28e. Dete of Injury (Month, Dey Year) 28b. Time of

2 ☑ ER/Outpatient 3 ☐ DOA 28c. Injury et Work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 Suicide 4 Homicide

27. Menner of Death

1 Naturet

2 Accident

6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

22 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and menner stated.

29b. Signeture and title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) MAY 08, 1999

30. Name and address of person who completed cause of death (Item 25e) (Type, Print)

adentz. 5. phyn

31. Dete filed (Month, Dey, Year) MAY 1 4 1999

32 Aegistrer's Sign

111 Penn Street, Baltimore, Maryland 21201 souls

State Registrar

and to ment

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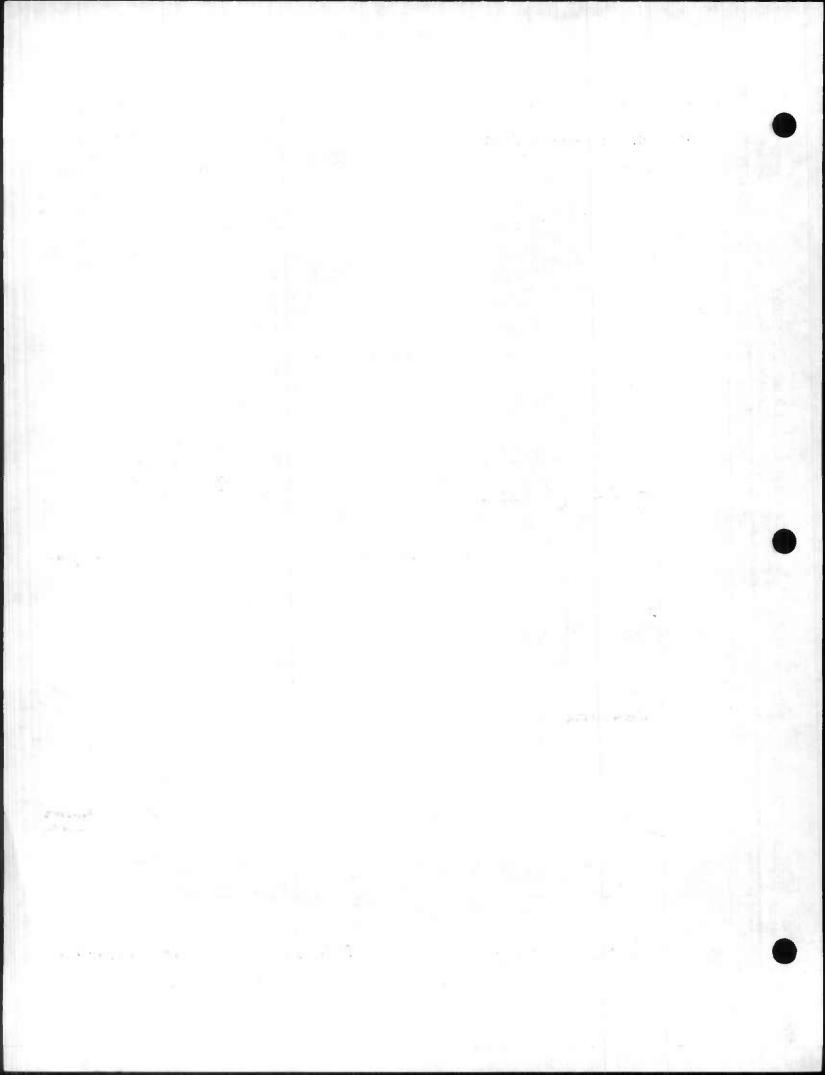
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 13° Dominic Anthony Centobene May 1999 6:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bryant Woods Inn Assisted Living Columbia Howard Co. If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Sept. 27, 1914 Birthplace (State or Foreign Country) Funeral Days 1X) M 2D F Months Hours 170-18-9644 84 Altooná, Pa. Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Maulcal Executive must be notified at 1 Yes 2 No Howard Co. Maryland Columbia Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5076 Lake Circle West 21044-1442 United States of America Funeral Pages 1 and 2 should be flied within 72 hours after death nent of Health and Mental Hyglene.

Mit: If Hear 27 ia marked other than "natural", or hama 23, my or other traumatic event, the Mental Earth of my many or other traumatic event, the Mental Earth of the Mental Communication 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarlo Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indien 11. Marital Status Black, Whita, atc 1 ☐ Never Married 2 ☐ Married Baltlmore, Maryland 21215-0020 1 Yas 2XX No Specify Specify: P White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Self Employed Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Joseph Centobene Josephine Vena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Joseph D. Centobene (Son) 5076 Lake Circle West Columbia, Maryland 21044-1442 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 DiOther (Specify) Entonoment permit. Page Department of Important: If any Injury or page. Dulaney Valley Memorial Gardens 5/17/1999 Timonium, Maryland Jeffrey L. 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Ligarus Ten or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one bause on each line. Approximata tritarval Batween Onsat end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). physician the buria Box 68760. Physician/Medical Dua to (or as a consequence of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yea 2 No 3 Probably 4 Junknown DEMUNTIA À 24b. Were autopsy findings evailable prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 3 NO 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: funeral director, 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 NO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manney of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the To the To the I 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D 51860 13, 1999 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3460 Ellicott Center Drive Suite 103 Ellicott City, Maryland 21043 Jonathan Fish, M.D. 31. Data filed (Month, Day, Year) MAY 1 4 1999 32. Registrar's Signatura State

DHMH 16 Flev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** : 20 PM 13 MA NANCY ANN DTNAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner STELLA MARIS HOSPICE AT MERCY BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dev. Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min 1 M 2 XF Yrs. 220-30-5755 64 Jan. 09 1935 Director Maryland Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show inotified at 1 ☐ Yes 2 ☐ No Director Md. n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or treumstic event, the Modical Examiner must be a permit. Pages 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or the any Injury or other traument. 1109 William Street Funeral 21230 USA 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white p 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 0 Home Owner 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Mary Cumberland Thomas R. Fitzgibbons 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) William F. Dinan 1109 William Street, Baltimore, Md. 21230 (Husband) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Suriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Holy Cross Cemetery 5/17/99 Brooklyn Park, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervel Between Onset apd Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examiner and I-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence ot): physician ar s the burial-t Division of Vital Records, P.O. Box 68760, that the death certificate be Physician/Medical Due to (or es e consequence of) 65 65 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached 2 No 3 Probably 4 Unknown py 24b. Were autopsy tindings evelleble prior to completion of ceuse of deeth? Completed 24a. Was an autopsy performed? page 2 : 1 ☐ Yes 2 No **TELYOS** certificate Hospital or Attending Physicien: funeral director, 26. Plece of Deeth (Check only one) A MARIS AT MORY 25. Wes cese referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 John (Specify) W > mr 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Manper of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After Naturel 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) edicai completely To the I within 2 29b. Signature end title of centler 29c. License number 29d. Date signed (Month, Day, Year) D40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 1 St Part Pl 21202

DHMH 16 Rev 6/95

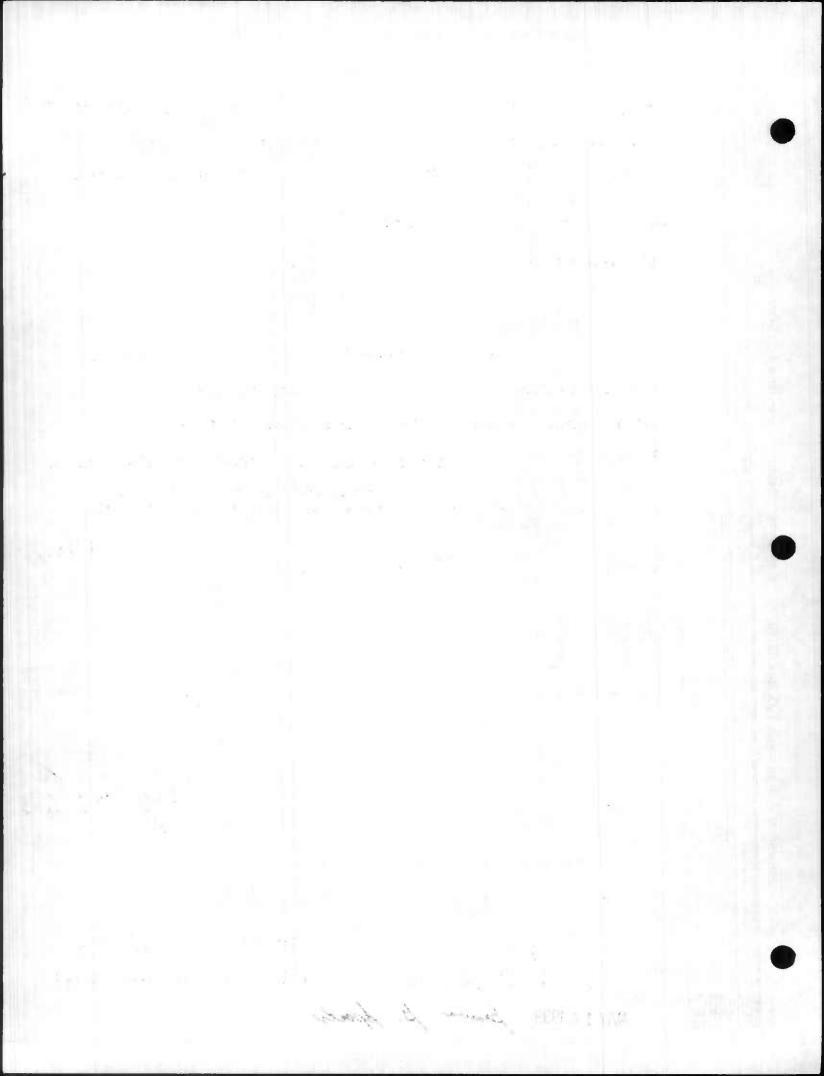
State

Registrar

31. Dete filed (Month, Dey, Year)

MAY 1 4 1999

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#8 per FH G771 5/14/99 EW 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** DUKE DORIS 6:45 AM 1999 MAY 10 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) If Under 1 Year 1913 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2MF Months Days Hours Yrs. MAY 17 1917 194-03-4917 85 ENGLAND **Director** Usual Rasidance of Dacedant the Marylenc 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show 1 ☐ Yas 2 ☐ No CAMBRIA BARNESBORO Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code in then "netural", or items 23s or 148 GARDNER RUN ROAD 15714 USA Funeral death 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxicen, Puerto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Haalth end Mental Hygiena. Important: if Item 27 is marked other than "natural", or hen sny injury or other traumatic event, the Medical Exaction 1 Navar Marriad 2 Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Spacify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 18. Mothar's Nama (First, Middle, Meidan Sumama) 17. Father's Nama (First, Middla, Last) Be **JAMES** ABBOTT FLORENCE 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) CHRISTINE WHITNEY, DAUGHTER 7109 HADLOW DRIVE, SPRINGFIELD, VA 22152 20b. Placa of Disposition (Nama of cemetery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ₩ Burial 2 Cremation 3 Ramovel from Stata NORTH BARNESBORO CEMETERY BARNESBORO, PA 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 21. Signature of Junaral Service Licensea 736 EDMONDSON AVENUE, BALTIMORE, MD 21228 23a. Pert1. Enter the disaasa, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Death Physician Immediata Causa (Final disaasa or condition resulting in deeth) /Medical failure Congestive Heavt 4 days Examiner Examiner ician end bunal-trans Sequentially list conditions, if any, leeding to immadiata ceusa. Enter Undarlying Cause (Disaase or injury that Initiated evants Dua to (or as e consequence of): ettending physician for use es the buna that the death certificate be Physician/Medical Dua to (or as a consequence of) rasulting in deeth) Lest 80 detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cancer Gastric þ 24b. Were autopsy findings evailable prior to complation of ceusa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No certificata Be 25. Was cesa rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residance 6 Othar (Specify) 10 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Box 68760, P.O. Division of Vital Records, or Attending Physician: After this funeral Certification: 24 hours after deet Funeral Director: Hospital

altimore,

29a. Certifier (Check only one)

27. Mannar of Death 1 Natural 2 Accident 3 Suicide 4 Homicida

29b. Signeture end title of certifiar

5 Panding Invastigation 6 Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of

28a. Place of Injury - At homa, farm, streat, fectory, office building, atc. (Spacify)

1 Certifying Phyeician: To the bast of my knowledge, death occurred at the time, deta and place, end due to the causa(s) and manner es stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. 29c. License number

1 Yes 2 No

28c. Injury at Work?

29d. Deta signed (Month, Day, Year)

Location (Streat end Number or Rural Routa Number, City or Town, Stata)

D37891 10 1999 MAY

28d. Dascribe how injury occurred

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print) | Ln # 409 Rockville, MD-20852

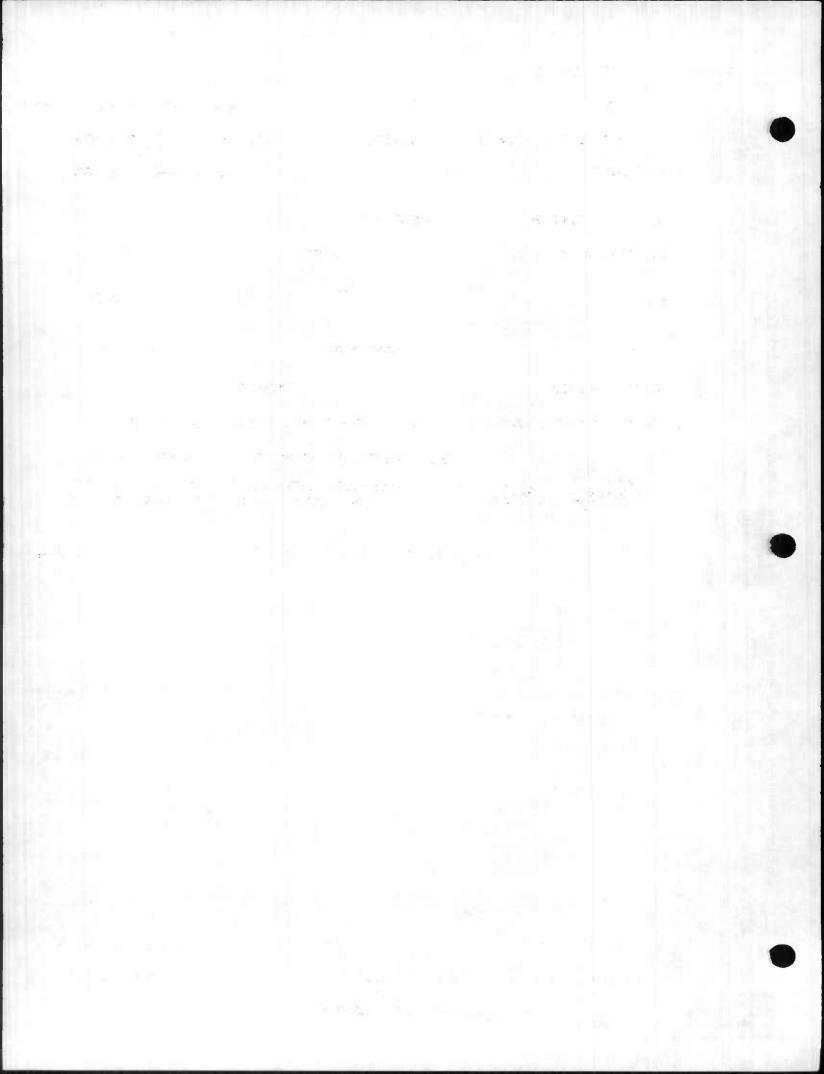
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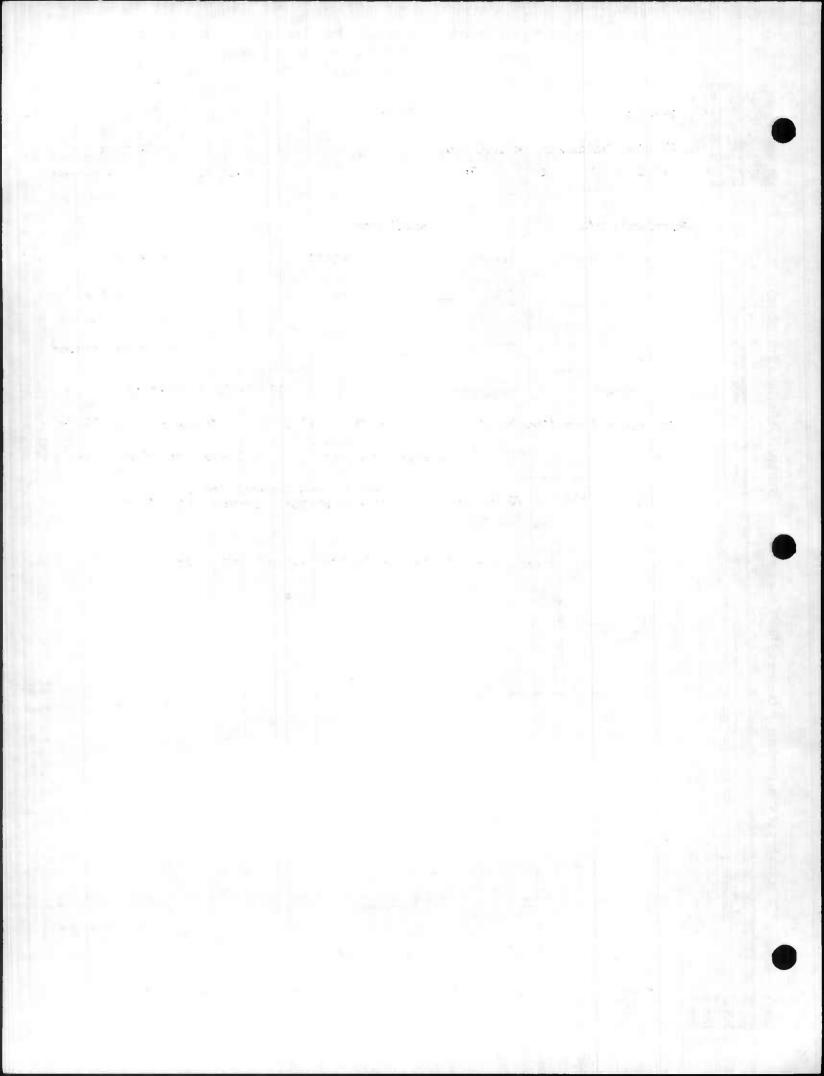
32. Registrar's Signature souls

within 2 To the



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ast) ive street and number)				2. Date of Dea	ath	3. Time	of Death				
ive street and number)				Month Month	Day	Year	. Juni				
ive street and number)	Dudder	ar		May 1	-		10 am				
			4b. City, Town, or Lo	cation of Death	4c. County	of Death					
Greater Baltimore Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr											
Sex 7. Age (In	yrs. last birtingay)	If Under 1 Year Months Deys		8. Dale of Birtl (Month, De)	r, Year)	Birthplace (State Country)	or Foreign				
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Usuel Residence of Decedent											
10	c. Ony, TOWN OF LOC	attori				10d. Inside (2 No				
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		10f. Zip Code			10g. Citizen of V	Vhet Country?					
er Street		212	05		U.S.	Α.					
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				nican, etc.)							
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contributing to death but no	ot resulting in the un	deriying cause gi	iven in Part I.	23b. Dld t	obacco use co	ntribute to the cause	of death?				
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						24b. Were autopsy	findings				
				perto	medi	completion of					
				X_			-				
				101	res 2□No	Y Yes 2	J No				
Manakat		I =	26. Plece of Deetl	(Check only o	ne)						
Hospital:	2 ER/Outpatient	3LI DUA	her: 4 Nursing Ho	me 5□Resid	dence 6 □Oth	er (Specify)					
28e. Dete of Injury (Month, Dey Ye	28b. Time of Injury	28c. fnju Wo	iry et ork?	28d. Describe h	now injury occur	red					
1X Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2											
	At home, farm, sire	et, factory, office		28f. Location (Street and Number or Rural Route Number,							
be 28e. Placa of Injury -											
be 28e. Placa of Injury -											
28e. Placa of Injury - building, etc. (S	y knowledge, death			and due to the	cause(s) and ma		(e)				
28e. Placa of Injury - building, etc. (S	y knowledge, death			and due to the	cause(s) and ma		(s)				
28e. Placa of Injury- building, etc. (S	y knowledge, death	estigation, in my		and due to the ded at the time,	cause(s) and ma						
28e. Placa of Injury- building, etc. (S	y knowledge, death	estigation, in my 29c. Licen	opinion, death occurr se number	and due to the ced at the time,	cause(s) and madete end plece, 29d. Dete signed	end due to the ceuse					
28e. Placa of Injury-building, etc. (S) Physician: To the best of mainer; On the basis of exa and manner steted.	y knowledge, death iminetion end/or inv	29c. Licen	opinion, death occurr se number	and due to the ced at the time,	cause(s) and ma	end due to the ceuse					
28e. Placa of Injury-building, etc. (S Physician: To the best of muminer: On the basis of exa and manner steted.	y knowledge, death iminetion end/or investigation with the second	29c. Licen D3020 Print)	opinion, death occurr se number	and due to the ded at the time,	cause(s) and made determined the det	end due to the ceuse					
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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death 12:18 Pm Joseph 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Hospital Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 11XM 2 F Yrs July 13, 1937 unknown 213-34-7488 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 15 Yas 2□No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1818 Aliceanna Street 21231 unknown 12. Was Decedent Ever in U.S. Armed Forces? unknown 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced unknown 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) unknown unknown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) unknown unknown 20b. Place of Disposition (Neme of 20a Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ₺ Other (Specify)in state 21. Signature of Futeral Service Licenses 22. Name and Address of Facility State Anatomy Board, Baltimore, MD 21201 655 W. Baltimore Street man Baltimore, MD 21a. Fart. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of) nemonia Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? morrosedar 2PINO 1 Yes 1 Yes 2 No 196USE 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physiclan /Medical Examiner

Pue

signed by the

Records, P.O. Box 68760

Division of Vital

permit. Pages 1 and 2 should be lifed we Department of Health and Mental Hypier Important: if item 27 is marked other the any injury or other traumetic event. the

Physician

/Medical

Examiner

Funeral

Director

natural, or items 23a or 28a-f show

Director

Funeral

þ

Completed

36

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NAME KNOWN TO PHIS

altimore, Maryland 21215-0020

Physician/Medical þ Completed Be

attending physician for usa as the buria 8 edical Certification:

1. Netural

2 Accident

3 Suicide 4 Homicide

(Check only one)

29a. Certifier

this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; a

> State Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Dey, Year) MAY 1 4 1999 4

29b. Signature and title of certifier

5 Pending Investigation

6 Could not be determined

Broadway 32. Registrar Signature

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dev. Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dev **Physician** Eldridge, 1999 Jr. May 11 8:11am /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□ F Yrs. Director 69 214-26-0142 Oct 14, 1929 North Carolina Usuai Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show. must be notified at 1 ☐ Yes 2 ☑ No Directo 28a-1 Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? naturel", or hams 23s or 219 Rickswood Road 21093 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ∑ Yes 2 ☐ No 1 ☐ Never Merried 21 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: À 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1951-1953 White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 Controller Aerospace permit, Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If New 27 is married offer any Injury or other in-17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Meredith Eldridge, Sr. Wilson Marie 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Marie Eldridge/Wife 219 Rickswood Road, Timonium, Maryland 21093 20b. Piaca of Disposition (Name of cemetery, crematory or other place)Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 🕅 Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore-Washington 5/14/99 Laurel, Maryland 21. Signature of Funerel Service License 22. Neme end Address of Facility Lemmon Funeral Home Boland Gullar 10 W. Padonia Road, Timonium, MD 21093 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner omeo that the death certificate be axecuted and Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. physician Oronany Physician/Medicai the th Due to (or as e consequence of). Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2□ No 3 Probably 4 Unknown signed t Chronic þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edicai Certification: To this 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 1 Neturat 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted. To the Within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D3488 ROODER MID May 12, 1999 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

St., Baltimore, MD

21287

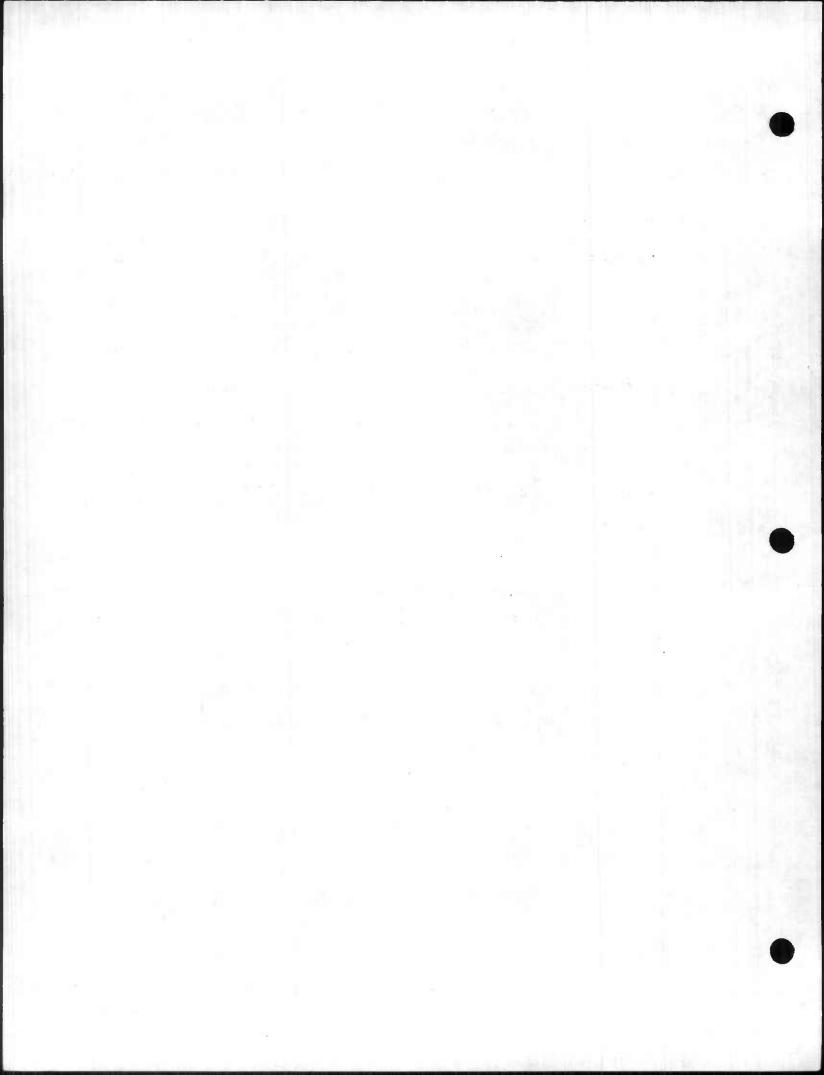
600 N. Wolfe

32 Pagistrar's Signature

M.D.

Edward Kasper,

31. Date filed (North Pay Year) 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month SOM Yaar 99 Hnna 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) Center-Genesis Green Eldercare Baltimore 5. Social Sabdrity Number If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (State or Foreign Country) 6. Sax 7. Aga (In yrs. lest birthdey) 10M 2XF Days Hours 216-67-3460 Yrs Maey Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Ma 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 18 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No ff Yas, Giva Yaar or Datas: 11. Marifal Sfafus Was Decedant of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc 1 Nevar Marriad 2 Married 1 Yas 2 No Specity: White Specify: 35 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Elementery/Secondary (0-12) Collega (1-4or 5+) 17. Fafhar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumema) nnie 19a. Informent's Name/Raietionship (Type Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Steta May 15 1 Surial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) 21. Signature of Fonaral Sarvice Licensag 22. Nama and Addrass of Facility VANS 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arres shock, or heart failure. List only one cause on each line. Approximate fntarval Batween Onsaf and Death Immediata Causa (Final disaasa or condition rasulting in deeth) ASHD Years Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that initiated avants rasulting in death) Last Dua to (or es a consequance of) Dua to (or as a consaquance of) Part if. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part it. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Demont 24a. Was an autopsy

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

31

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 23a-4 show any injury or other treumstic event, the Medical Exercites must be notified and entered.

Baltimore, Maryland 21215-0020

Examiner physician and s the burial-transit Physician/Medicai þ Completed 25. Wes case raferred to medicel axaminar? Be

ettending pl been signed by the e should be deteched t certificate hes t director, page 2 s funeral director, Certification: To this After affer death.

The law requires that the death certificete be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Recent ouset Amial Sibultation

26. Placa of Death (Check only one)

24b. Wara autopsy findings available prior to complation of cause of deeth?

1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

2 No

1 Yas

28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Tas 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, ferm, sfreaf, factory, office building, atc. (Specify)

Certifying Physician: To the best of my knowledge, daath occurred at tha time, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On tha besis of axaminetion and/or invastigetion, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar stated.

29b. Signature and title of certi

5 Panding invastigation

6 Could not be

1 Yas 25 No

27. Mannar of Death

1 Natural

2 Accidant

4 Homicida

3 Suicida

29a. Cartifian

edical

red al Attendona

1 | Inpafiant 2 | ER/Outpatient 3 | DOA

28b. Tima of

29c. Licansa number

29d. Data signed (Month, Day, Year)

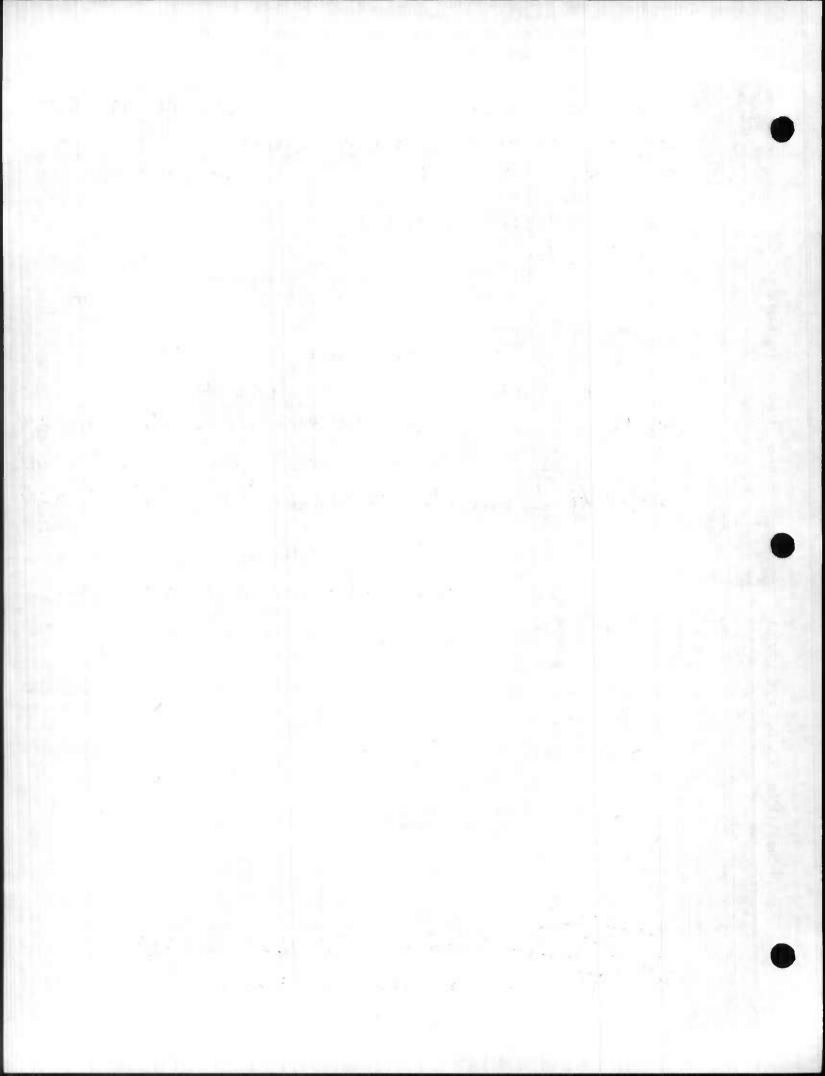
address of person and complated ceusa of death (Itam 23a) (Type, Print)

115 F. Molrose 21212 Schwartz M.D. 31. Data filed (Month, Dey, Year) 32. Ragistrer's Signature

State Registrar

4

To the Hospital or within 94 hours at To the Funeral D completely filled



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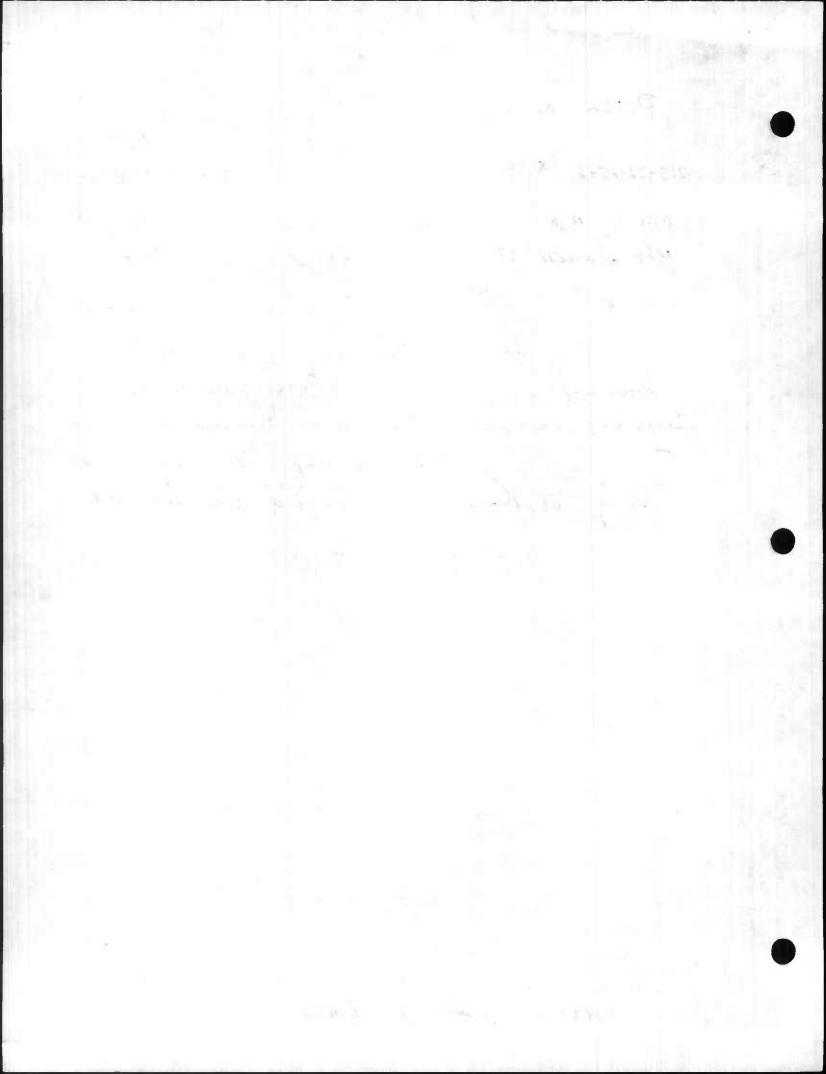
State of Maryland / Department of Health and Mental Hygiene

				Certificate	of Death	Reg.	No.	2001				
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	Physiciar /Medica	PETER R. ELY				MAY 11,	10815 Δ					
	Examine	An English Blamp /// not incititation also attend and number			4b. City, Town, or BALTIM	Location of Death	4c. County of Death					
5-0020 72 hours efter death with the Maryland netural; or frame 23e or 28e-f show size Examines must be notified as	Funeral	5. Social Security Number 6.		vrs. last birthday) If Under 1			9. Birth	nplace (Stete or Foreign				
	Director	213-26-1546	12(M 2□F	6 Yrs. Months	Days Hours Mir	Oct 201		RYLAND				
	p .	Usual Residence of Decedent						/				
	anyles anyles	10a. State 10b. County	100.	City, Town or Location				10d. Inside City Limits 1. ☐ Yes 2 ☐ No				
	M and	MD N	A	DAUTO,				/-				
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20	0	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1□ Yes 2	No Specify:		Specify:	17=				
21215-0020	netural	15. Decedent'a		16a. Decedent's Usual	Occupation	168	b. Kind of Business/li	ndustry				
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21	d within plane. r than	15. Decedent's (Specify only highest g	N/4	SALesm	LAN		NovelTiE:	\$				
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/la	D 2 3 0	-JOHN ELY			CATHE	RRINE 1	METHOU	U.				
Maryland	2 shoul end Mi ie meri eumeti	19a. Informant'a Neme/Relationship	(Type, Print)	19b. Mailing Address	Street and Number or F	iural Route Number, C	ity or Town, State, Z	ip Code)				
-	4450	JAMES ELY (E	BROTHER)	18.33 Wi		DUNDOCK	2/222	Md.				
ore	0 2 2 0	20a. Method of Disposition	20a. Method of Disposition 20b. Place of Disposition (Name of competion 2 December, cremetory or other place) 20c. Location - City or Town, State									
E	nit. Pages entment of i ortent: If its injury or o	4 Donation 5 Other (Specify) Western Cometery 199 Dougs, MD.										
Baltimore	pemit. Page Department of Important: If eny injury of once.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility DELLA NOLE + SONE FUNCRAL +ONE										
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	/Medical Examiner	Immediate Cause (Final disease or condition	Athero	sclustic (ardiovas	ular D	escase					
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68760,	ng physicia as the bur	that initiated events resulting in death) Last	Due to	o (or as e consequence of):								
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00						performed	C	vailable prior to completion of cause of death?				
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Vital	certificata rector, pag				OR Diseased D	1 Yes	2000 1	☐ Yes 2☐ No				
5	Physician: this certificated director,		Hospital:	2 ☐ ER/Outpatient 3 ☐ DO/	Other	Home STResidenc	a 6 DOther /See					
o	tending Physical Act the funeral di		28a. Date of Injury (Month, Day Year		c. Injury et Work?	28d. Describe how		"77				
o	After fun	1 Natural 5 Pending 2 Accident investigati		njury M	Work? 1 ☐ Yes 2 ☐ No							
Division	ball or Attending P is after death. al Director: After the in by the funers	3 ☐ Suicide 6 ☐ Could not determine	1 286. Place of injury - A	It home, ferm, street, fectory,	office		et end Number or Ru	rel Route Number,				
5	Di Di	TITOMICO	building, etc. (Sp.	oury)		City or Town, S	1010/					
	hour hour hy fills			knowledge, death occurred a								
	he Hosp in 24 hou he Fune pletsly fil		miner: On the basis of exam and manner stated.	inetion and/or investigation, i	n my opinion, deeth occ	curred et the time, date	end place, end due	to the cause(s)				
	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	29b. Signature and title of certifier	001	29c.	O.C.M.E.		Date signed (Month					
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State Registrar

MAY 14 1999

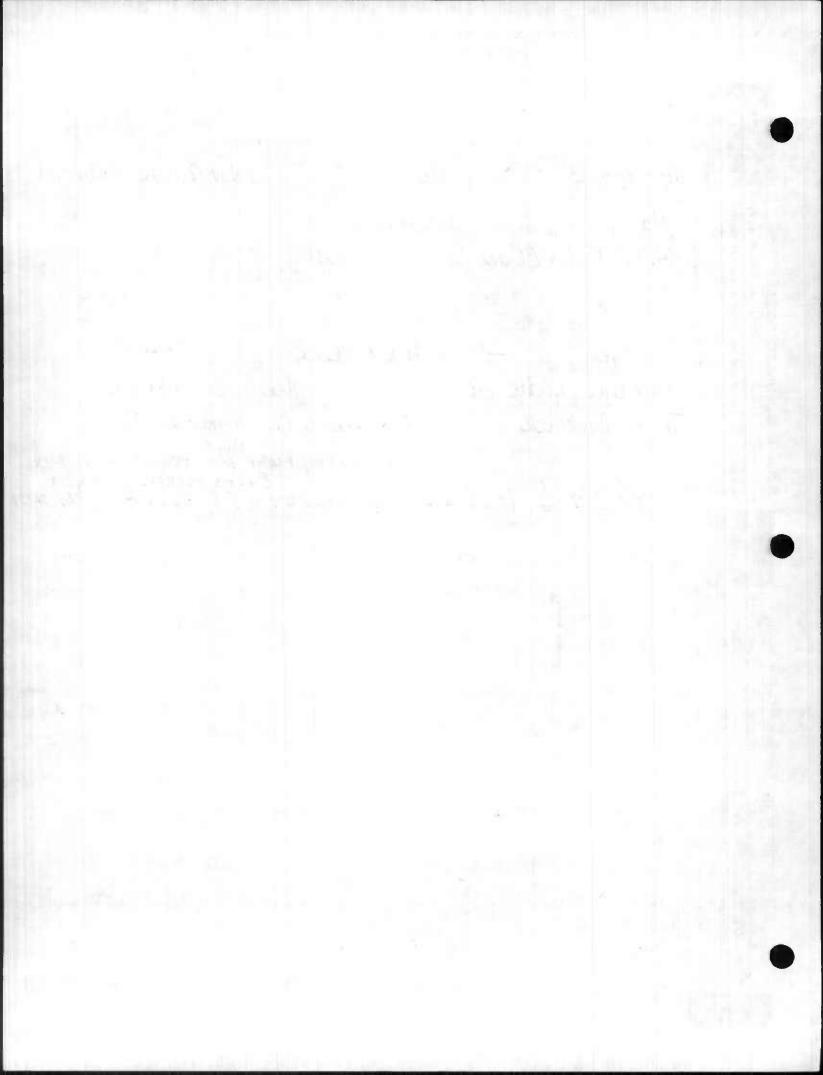
Chufe will Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 081 MARCIA FRITZE 3:30 1999 MAY /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give streat and number) Examiner HOSPITAL OF BALTIMORE BALTIMORE 9. Birthplace (State or Foreign Gountry) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 KF 218-38-4333 Usual Residence of Decedani Yrs 560 **Director** VOV. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Modical Examiner must be notified at 1 Yes 2 No Director Md 10g. Citizen of What Country? 10e. Sfreet and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours eftar deeth v Department of Heelth and Mental Hygiene. Insportant: If Item 27 is marked other than "natural", or itema 23a eny injury or other treumatic event, the Medical Exercises 2008. 2/2/ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 💢 No Specify. Specify: White by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clo P 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) PUCOU 20a. Method of Disposition 20c. Location - City or Town, State 10 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licenses Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical SEPSIS IDAY Examiner Dua to (or as a consequence of): Physician/Medical Examiner METASTATIC 1 YEAR CANCER RECTAL ettending physician and for use as the bunal-trans Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Due to (or as a consequence of): USB as 1 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Ø Unknown Division of Vital Records, P 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 should certificate has 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was cese raferred to madice examiner? Be 26. Place of Daath (Chack only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No hin 24 hours efter death. the Funerei Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 12 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, date and place, and due to tha causa(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 2 29b. Signatura and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eversley P # 10413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 BELVEDERE AVENUE, BALTIMORE MARYLAND 31. Dale filed (Month, Dey, Year) 32. Registrar's Signature State MAY 1 4 1999 Registrar

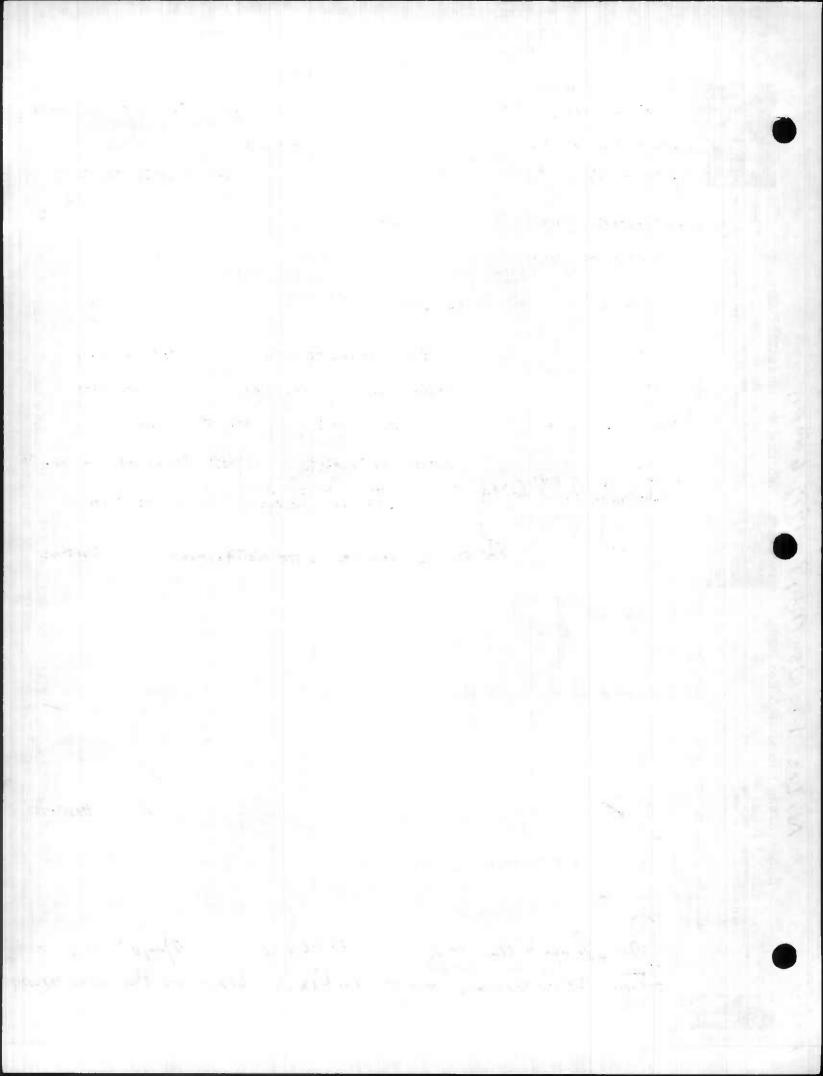


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Yaar **Physician** 09 1999 Niles Emory Fields May 6:40pm /Medical 4b. City. Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore N/A If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Lindar 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** Days 1⊠M 2□F **Vrs** Director 216-18-7345 76 March 25,1923 Maryland Usual Rasidance of Decedant with the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 10a. Stata Item 27 is marked other than "natural", or fame 23a or 28a-f ahow other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Pennsylvania York York 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 367 Hillcrest Road 17403 USA Funerai death 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Rece - Amaricen Indian, Black, Whita, atc. 1 ☑ Yas 2 ☐ No If Yes, Giva Year or Dates: 1942—1946 filed within 72 hours after 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specity: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If fem 27 is marked other than "na any Injury or other treumetic event once. Elamantary/Secondary (0-12) Coilaga (1-4or 5+) 12 Sales Representative Paint Company 18. Mothar's Nama (First, Middla, Malden Surnama) 17. Father's Nema (First, Middla, Last) Be Niles Fields, Sr. Gertrude I. Snelling 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Victor L. Fields 1 East King Street, York, PA 17401 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Crametion 3 ☐ Removal from Stata 4 Donation 5 Othar (Specify) Spring Garden Twp. PA 5/13/99 Mount Rose Cemetery 2) Signature of Funeral Service Life 22. Nama and Addrass of Facility Lemmon Funeral Home 10 W. Padonia Road, timonium, MD 21093 a. or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, that only one cause on each line. Approximele Intarval Batween Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disaasa or condition rasulting in death) PROSTATIC CANCER WITH METASTASGS 24ETHS **Examiner** Dua to (or as a consaguanca of) FIEIDS MAY Examiner physician and the burial-trensit Sequentially list conditions, if any, laading to Immadiata cause. Enter Underlying Causa (Disease or injury that initialed avants resulting In death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): 88 9SD 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be dateched 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Offknown by 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed After this certificate has 2 No Division of Vital 25. Was cesa rafarred to medicel axaminar? Be 28. Placa of Daath (Chack only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Residence To 1 Yas 2 No 6 Dother (Specify) TO SPICE 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manne of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: 5 Panding Investigation 1 ☐ Yas 2 ☐ No death. 2 ☐ Accident or Attancatta death 6 Could not be datamined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide • Funeral [Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and place, and dua to the causa(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifier (Check only Within 2 To the 29b. Sidnatur and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed ceusa of death (Item 23a) (Type, Print) BMAC GIBBON W. RENDS1 SUITE 719 BAETMONE HD 2129 32. Angistrar's Signatura Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Month Day **Physician** 5 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner If Under 1 Year 9. Birthplace (State or Foreign Country) Mary ANA 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 10 M 200F 213 -20 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 746 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Specify: White 1 Yes 20 No Specify: þ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) apogiver 10 17. Father's Name (First, Middle, Last) 18. Muther's Name (First, Middle, Maiden Sumame) Be KRINER Wenhall nomas 19b. Meiling Address (Street and Number or Furni Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hoat 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, State May 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) EVALS Funeral (BeLAIR napel -22. Name and Address of Facility 21. Signature of Fuperal Serylce License vans Md 21234 236. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, with as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final MYOCARDIAL INPARETION disease or condition resulting in death) Examiner disease atherosclerotic Coronan arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Stenosis renal dys function þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

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Funeral

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filed within 72 hours after Hygiene.

. Peges 1 and 2 should be filed witnest of Health end Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, its

permit. Pege Department of Important: If any injury or once.

Physician /Medical

Examiner

Baltimore. Maryland 21215-0020

the Medical Examiner must be notified at

the Maryland

28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

152 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Patricia atarabelus 30. Name and address of person who corpoleted cause of death/(Item 23a) (Type, Print)

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Imonium, Md 21093

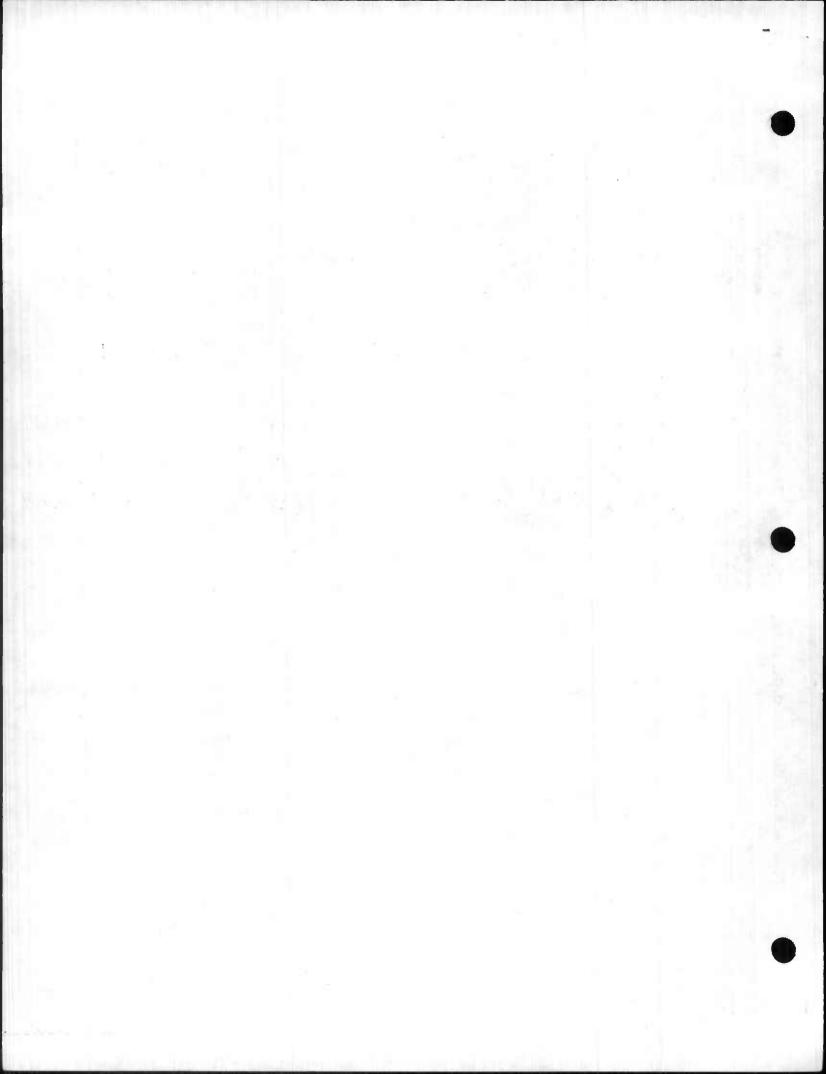
32. Registrer's Signature

State Registrar

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Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amended #10e per FH, G771, 5/21/99dhb ITEMS: #10B-C PER F.H. G771 5-14-99 WR. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Monthay Oriffin **Physician** 1999 2:45 PM lice /Medical 4a Facility Nama (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson If Under 1 Year 5 Social Security Number If Under 24 Hrs. 8. Data of Birth (Mon(h, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1□M 20 F Days Hours Min. 217-38-9417 Usual Rasidence of Decedent Yrs Director the Maryland r 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2 No OWINGS MILLS Director NSAC 10e. Street and Number Brightwater 10f. Zip Code 10g. Citizen of What Country? 6 permit. Peges 1 and 2 should be filed within 72 hours efter death with Department of Heelith and Mental Hygiene.

Department of Heelith and Mental Hygiene.

The marked other than "natural", or items 23a or siny injury or other traumatic event, in the fact of the marked other in the first permit in the fir 6 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Meritel Stetus 1 Yas 2 No
If Yes, Giva /
Year or Dates: 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ashier +4 NIA 10 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be litton Genston PU 19a. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boltimore Md2111 20b. Place of Disposition (Nama of cemetary, crematory or other place) amps Spouse 20c. Location - City or Town, State 20a. Mathod of Disposition Dete law andress of Fecility Bets Burial 2 Cremetion 3 Removal from State 5-17-99 woodlawn Mo Donation 5 Othar (Specify) funeral Home 21. Signature of Pineral Service Licens 22. Name end Address of Fecility Ballmore Md 21213 1129. N. Caroline st acur ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the first failure. Ust only one cause on each line. Approximate Interval Between Onset and Death **Physician** UREMIA MONTHS /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Due to (or as a consequence of):
CONGESTIVE HEART FAILURE 2 YEARS Examine the burial-transit Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) and Box 68760. attending physician Physician/Medical Dua to (or as a consequence of): P.O. Pert II. Other afgniffcant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yaa 2 No 3 Probably 4 Unknown DIABETES MELLITUS Division of Vital Records. by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peed certificate has 1 Yes 2 No 1 ☐ Yes 2 No 25. Was casa refarred to medical examinar? Be 26. Place of Death (Check only one) To Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred edical Certification: 28c. Injury at Work? 1 Natural
2 Accidant 5 Pending invastigation 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian (Check only one)

29b. Signetura and titla of certifier

29c. License number 29d. Data signed (Month, Day, Year) 19508

-11,1999

30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print)
NATIVIDAD D. DELEON, M. D., 7601 OSLER DRIVE, TOWSON, MD 21204

State Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** May 1999 Theresa E. Gogel 6:08 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street and number) Examiner Gilcrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Months Deys Hours 1□ M 25 F Yrs. 212-30-7585 Dec. 12,1934 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Dundalk Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 2019 Inverton Road United States Funerai 21222 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manager Shoe Company 12 years 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumeme) 10 Nelson Orr Marie Mullen 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Matt Gogel 2019 Inverton Road Baltimore, Maryland 21222 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 5/10/ 1999 Rossville, Maryland 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) month Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) HOSpice Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 27. Manner of Deeth 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and menner stated. 29d. Date signed (Month, Dey, Year)
May 7, 1999 29c. License number 0 25205 29b. Signature and title of certifier mo 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) N. Charles St. Balto. md 21208 GBMC A. Piley 6701 31. Dete filed (Month, Day, Year) 1999 32. Pagistrar's Signature

Registra

DHMH 16 Rev 6/95

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Modical Examiner must be notified at

Il Hygiene.

Depertment of Haalth end Mental Hygin Important: If Item 27 Ia marked other any Injury or other traumatic avent. If

Physician

/Medical

Examiner

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certificate

al or Attending Physician: Tis efter death.
If Director: After this certificated in by the funeral director, pa

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Box 68760,

Records,

Division of Vital

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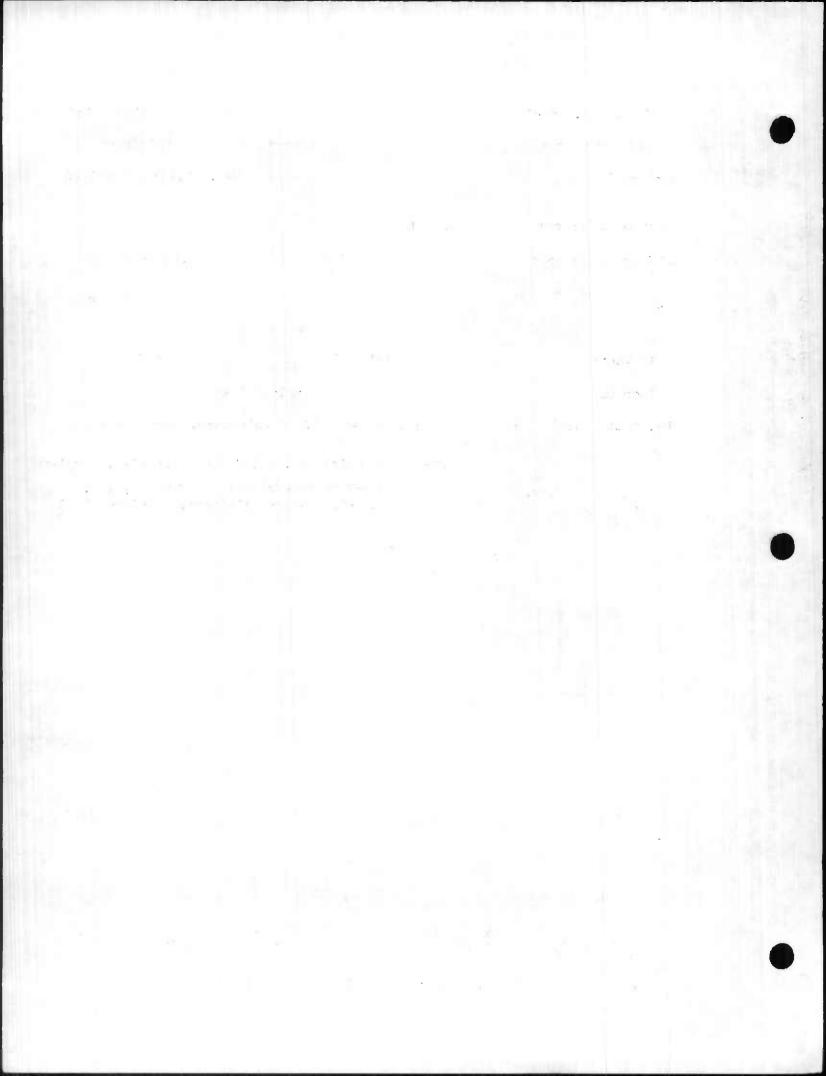
Pages 1 end 2 should be

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hours after death

MAY 7, 1994

HERESA GOGEL 0608AM



99-2654-003

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene

	HALL ITEM	S:	#23 PART I, 27, 28A-	F PER MEO	3771 5-19	WR .Cer	tificate o	of E	Death		Reg. No.	9	15687
	Physicia /Medica	n al	Decedent's Name (First, Middle, L Michael An	thony	Hall					2. Date of D Month MAY	9, 19	Yeer 199	3. Time of Death 9; 1.5P.M
	Examine	r	4a Facility Name (If not institution, g		ber)				o. City, Town, or Lo				
	Funeral Director		215-74-4574		. Age (In yrs. la	1st birthday) 28 Yrs.	If Under 1 Ye Months Da	ear	PASADENA If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	ay, Year)	9. Birth	place (State or Fore intry) Maryland
020	and ***	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limi	
	Marylan fahow	ğ									1 ☐ Yes 2 💢 N		
	7 28a	Director	10e. Street and Number	rit dilaci		1 030	10f. Zip Cod	de			10g. Citizen of	What Cou	intry?
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	urs a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 M Divorced	Armed For	2 🔼 No		Vas Decedent of Yes, specify C		spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	o- 14. Rad Bla Specif	ck, White	ican Indian, , etc. 11 te
Maryland 21215-0020	72 ho	Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give I	lent's Usual Oc	one du	uring most of work	ina	16b. Kind of B	usiness/ir	ndustry
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ary	E E E		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Str	reet a	nd Number or Flur				ip Code)
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Baltimore,	Pages 1 en tent of Heei nt: if Itam 2 iry or other		20a. Method of Disposition 1 D Burial 2 Cremation 3	☐Removal from S		nce of Dispos metery, crem	sition (Name of natory or other	place)	Date	20c. Location		
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Bal	pemit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lie	En)			Name and Ad		ain Road				Home, P.A.
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Ö	tal or and or an		4 D Homode	building, etc. (Specify) FOUND: RESIDENCE					A, MARYLAN		TERINE AVE.		
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral and a funeral actions of the funera	2010	29a. Certifier (Check only one)	hysician: To the be miner: On the bes and manne	is of examination	ledge, death on and/or inv	occurred at the estigation, in m	e time ny opi	e, date end plece, inion, death occurr	end due to the red at the time	cause(s) end m , date and place,	enner as	stated. to the cause(s)
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			Julyonte	Mynul			0.0	C.M	.E.		MAY 10,	1999	
			30. Name and address of person who	completed cause	of death (Item :	23a) (Type, F	Print)						
			M/2 W/3 M/3 Date filed (Month, Day, Year)	HORFY	pistra Cignatu	4	Lyl Pe	pn	Street,	Baltin	nore, Ma	rylar	nd 21201
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State of Maryland / Department of Health and Mental Hygiene 99 15688

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Certificate	of	Death		

ASP ITEMS	: #23 PART I, 27 PER MEO G771 5-24-99 WR. Certificate of Death	Reg. No.	10000							
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Physiciar /Medica	MUIN HAMILTON		999 2216							
Examine	4e Facility Neme (If not institution, give street and number) 4b. City, Town, c 6634 PIONEER AVE BALTIM	or Location of Death 4c. County	of Seath							
5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	11	9. Birthplece (State or Foreign							
Funeral Director	219-40-0668 19 M 20 F 56 Yrs. Months Days Hours Mi	in. B. Date of Birth (Month, Pey, Year) 42	Maryland							
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Balt permit. Depart import any inj ange.	Joseph Li Ku	iss Funera	I Home							
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/ /Medical Examiner	Immediate Cause (Finel disease or condition a. ACQUIRED IMMUNODEFICIENCY SYNDROME resulting in death)									
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DIVISION Of VITAL Requirements to the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth oc	ace, end due to the ceuse(s) end ma ocurred et the time, date end place.	anner es stated. and due to the cause(s)							
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8 4 8 4	O.C.M.E	MAY 11,								
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	Typical Duce m 111 Penn Stree	t, Baltimore, Ma	ryland 21201							
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature 6. Spouls									
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 12, 1999 RRVANT C HURLEY 8:05 AM 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 8069 LONG BRANCH TERRACE, T-1 GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Days Hours 1 XM 2 ☐ F Yrs 220-03-2713 76 NORTH CAROLINA MARCH 1, 1923 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8069 LONG BRANCH TERRANCE, T-1 21061 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PAINT & LABOR SUPERVISOR STEEL INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FELIX **GWYNN** HURLEY MOLLY **JOHNSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8069 LONG BRANCH TERRANCE, T-1 GLEN BURNIE, MD 21061 NANCY E. HURLEY (WIFE) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD. VETERANS CEMETERY 5-14-99 CROWNSVILLE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 1 SECOND AVE., S.W., GLEN BURNIE, MD 21061 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death arinary bladder Immediate Cause (Final disease or condition resulting in deeth) Casanema Due to (or ss a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of desth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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Physician

/Medical

Examiner

Funeral

Director

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State Registrar

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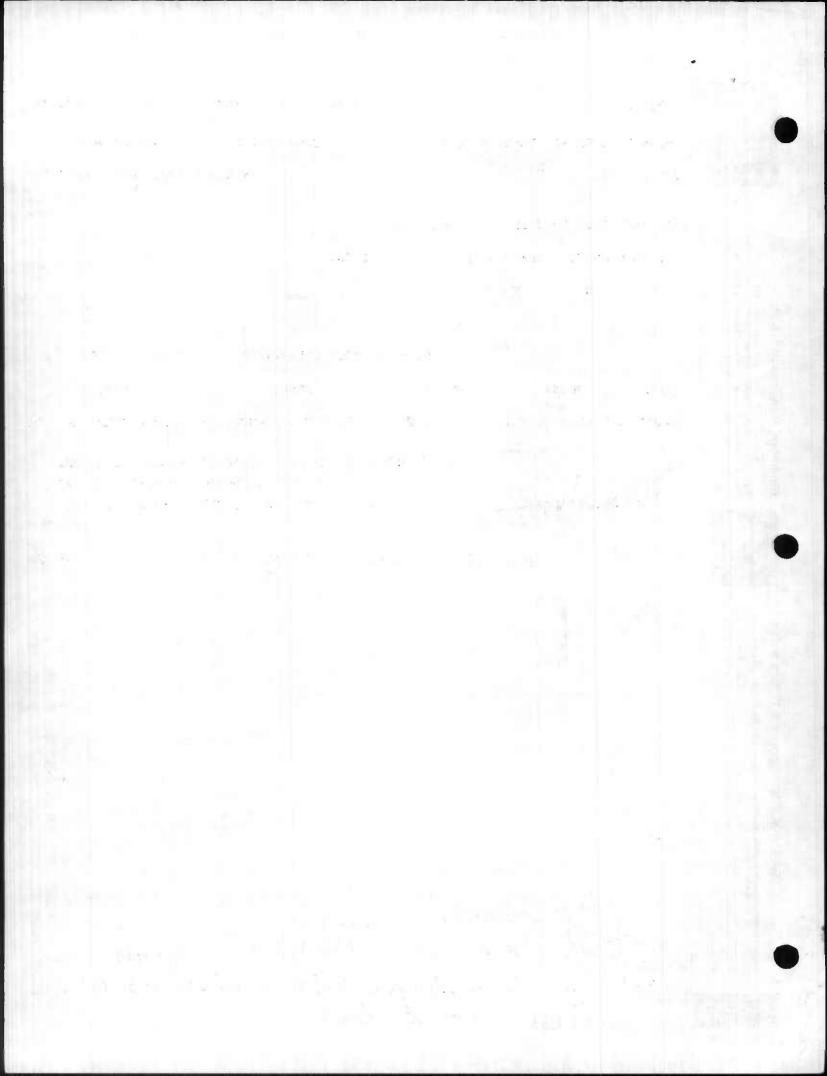
Certifying Physicisn: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

MD ress of person who completed cause of deeth (Item 23a) (Type, Print)

1413 Annapoles #106 odenton

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dav Month **Physician JAMES** OTTO HUGHES MAY 07 1999 8:30 am /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 1311 RUSTIC AVE. ROSEDALE BALTIMORE COUNTY If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months 100M 2□ F 74 Yrs. Director 218-18-1490 Maryland May 29 1924 Usuel Residence of Deceden 10e. Stete 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore County Rosedale 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 1311 Rustic Ave. 21237 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Bleck, White, etc. 1 Never Merried 2 Merried
3 Widowed 4 Divorced 1 XYes 2 No If Yes, Give Year or Detes: . 0. 1 Yes 2 No Specify: Specify: white by Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 10 0 Shortway Radio Repairman U.S. Federal Government permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Itan 27 is marked oth any Injury or other traumatic avant Rotes. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be 2 Otto E. Hughes Erma Ayler 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Kathleen Hughes (Wife) 1311 Rustic Ave., Rosedale, Md. 21237 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dele 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 5/10/99 Glen Burnie, Md. 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230 anes 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Emphysema Examiner Physician/Medical Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach Carcinoma 1. Yes 2 No 3 Probably 4 Unknown Be Completed by Bronchagenic Carcinoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 29e. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 29c. License number 1 cmore rus 517199 end D46365

DHMH 16 Rev 6/95

State Registrar

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Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

Box 68760.

P.O.

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Division of Vital or Attanding Physician:

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Hospital or Attand
 24 hours after death
 Funeral Diractor: /

within 2 To the 4

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MAY 1 4 1999

Wendy C. Moore, MD

31. Dele filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore VA Medical Center

ORIGINAL

10 N. Greene Street Room 3D-127

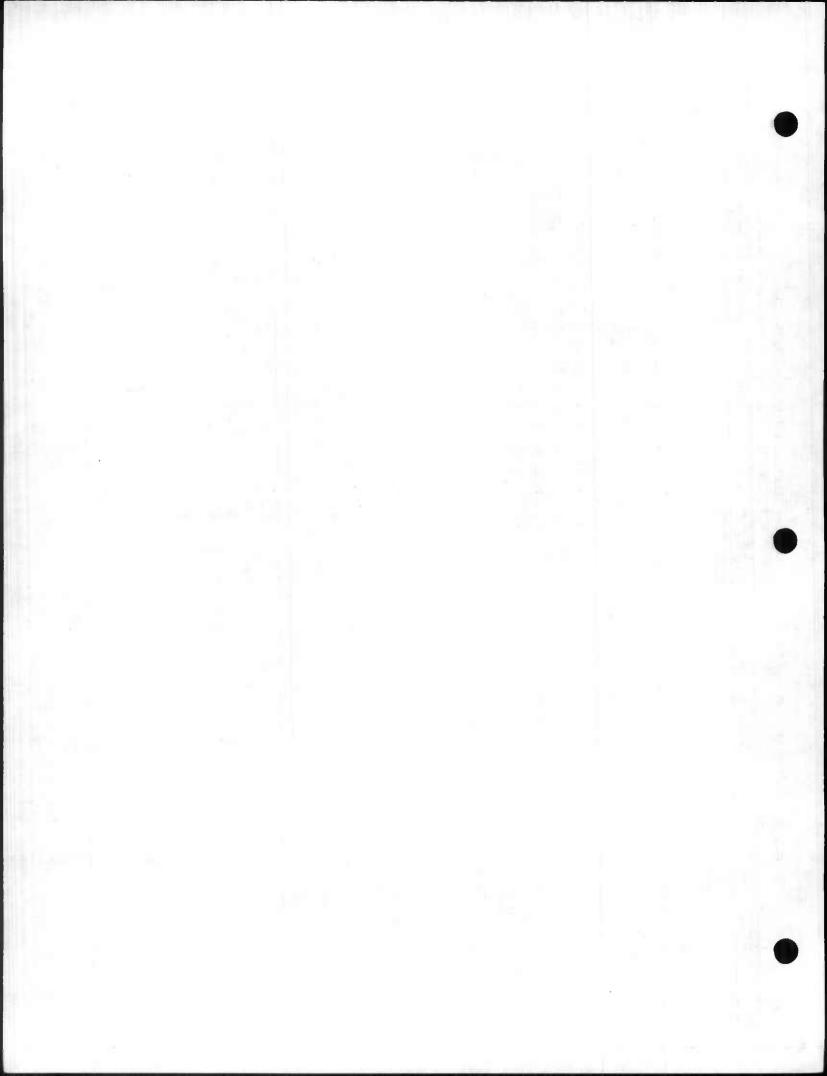
Baltimore, Md. 21201

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State of Maryland / Department of Health and Mental Hygiene 99 15691

			Ce	rtificate	of L	Death			Reg. No.	2	0001	
	1. Decedent's Neme (First, Middle, L	ast)						2. Date of De			3. Time of Death	
Physician	Margaret No	la Harvey						Month May	Day 19	Year 99	6:30pm	
/Medical Examiner	4e Facility Nema (If not institution, gi				4	b. City, To	wn, or Lo	ocation of Death		ty of Deeth	0.305	
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Funeral		Sex 7. Age (In yrs.		If Under 1	Year		24 Hrs.			-		
Funeral Director	215-22-6992 Usuel Residence of Decedent	1□M 2⊠F 97	Yrs.	Months	Days	Hours	Min.	Feb 17	e of Birth nth, Day, Year) 9. Birthplaca (State or Fore Country) 17, 1902 West Virgini			
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should by and marked umarked	19e. Intorment's Neme/Relationship		19h Mailie	na Address (Street	and Numb		al Route Numb				
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	shock, or heart teiture. List only	one cause on each line.								i	Interval Between Onset end Death	
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death. death. for: Affert the funeral cation:	27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time or Injury		. Injuny Work			28d. Describe	now injury occ	nued		
Arrending or death. ector: Affei by the fune iffication	2 Accident Investigation			М	10	Yes 2	No					
after death Director: d in by the	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 28f.						28f. Location (City or Tox		nber or Rur	al Route Number,		
an or Attending rate of the function: Certification:												
within 24 hours after de To the Funeral Directo completely filled in by it	29e. Certifier 1\overline{\text{\ti}\text{\texi{\text{\texi{\texi{\texi{\texi\tin\texi{\tex{\texi}\texi\texi{\texi{\texi{\texi{\texi{\texi{\texi{\tex	nysician: To the best of my know miner: On the basis of examinet and menner steted.	wledge, deeth ion and/or in	n occurred et vestigation, in	the tim	e, date en pinion, des	d place, th occurr	end due to the red at the time,	cause(s) end r date and plece	nanner as s e, and due t	stated. to the cause(s)	
ithin of the omple	29b. Signature and title of centrer			29c. L	icense	number			29d. Date sign	ned (Month.	Day, Year)	
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	30. Name and eddress of person who	completed cause of death (Item	23a) (Type,	Print)			- 1					
	Vipulkumar Bhalo	diya, MD 3007	E. No:	rthern	Pa	rkway	, Ba	ltimore	, MD	21214		
State	31. Dete filed (Month, Day, Year)	32. Registrer's Signe	ture									
Registrar	MAY 1 4 1999	peners D.	1000	uns								

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:55000 Mabel Hunter 5 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3111 Ardee Way 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days 1□M 2₩F Yrs 218-18-9611 Usuai Residenca of Decedent 89 Oct. 13, 1909 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Md. Baltimore Dundalk 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 3111 Ardee Way 21222 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes A ☐ No Specify: Specify:White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William Henry Gunter Margaret Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Leitner / Daughter 3111 Ardee Way, Dundalk, Md. 21222 20a. Method of Disposition 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 5-14-99 Balto-Wash.Crematory Laurel, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest,

Applications that caused the death. Applications that caused the death. Applications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest,

Applications that caused the death. Applications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest,

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Due to (or as a consequence of):

HYPO ALBUMENEMN 6 WEEKS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? MYELOPROLIFERATIVE DISORDER 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes al No 28c. Injury at Work? 28e. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected for use as the burial-transit completely filled in by the funeral director, page 2 should be detected for use as the burial-transit P.O. Box 68760. of Vital Records, Division

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show social Examination political at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Event

Physician

21215-0020

Baltimore, Maryland

Director

Funeral

b

Completed

Be

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

3 Suicide

4 Homicide

Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

27. Manner of Death 1 Naturai 5 Pending Investigation 2 Accident

1 ☐ Yes 2 ☐ No

28e. Piace of injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 29b. Signature and title of certifier

8 Could not be determined

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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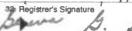
29d. Date signed (Month, Day, Year)

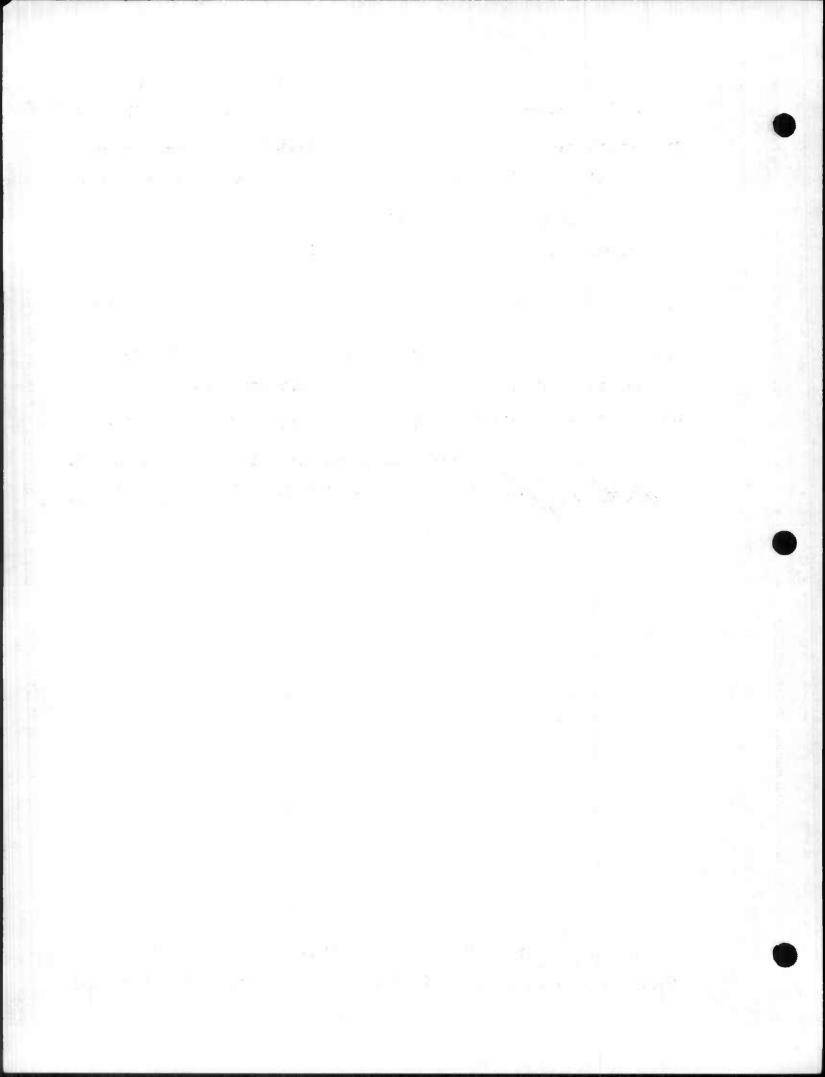
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DAVID 8- ZAJANO MD. STE 205 9101 FRANKLINSE CARE OR. BALTO MP 21237

Registrar

31. Date filed (Month, Day, Year) MAY 1 4 1999





Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Physician 2045 May Zeola Hughes 12 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number LNK 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2 F Days Months Hours 6-18-1923 75 Louisiana Director Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. Count 10d. Inside City Limits show Md. N/A **Baltimore** Yas 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 1004 N. Central Avenue 21202 USA "natural", or harns 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiena. Important: if Item 27 is marked other the any injury or other trausment other the ABSE. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Never Married 2 Married Black 1 ☐ Yas 2 No Specify: Specify ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Second 12 th condary (0-12) College (1-4or 5+) Presser Dry Cleaners 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Malden Sumama) 8 Houston C. Cole Lessie Crompton 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Howard Jackson (Son) 1004 N. Central Ave. Baltimore, Maryland 21202 20b. Place of Disposition (Nama of cemetary, crematory or other p 20a. Method of Disposition

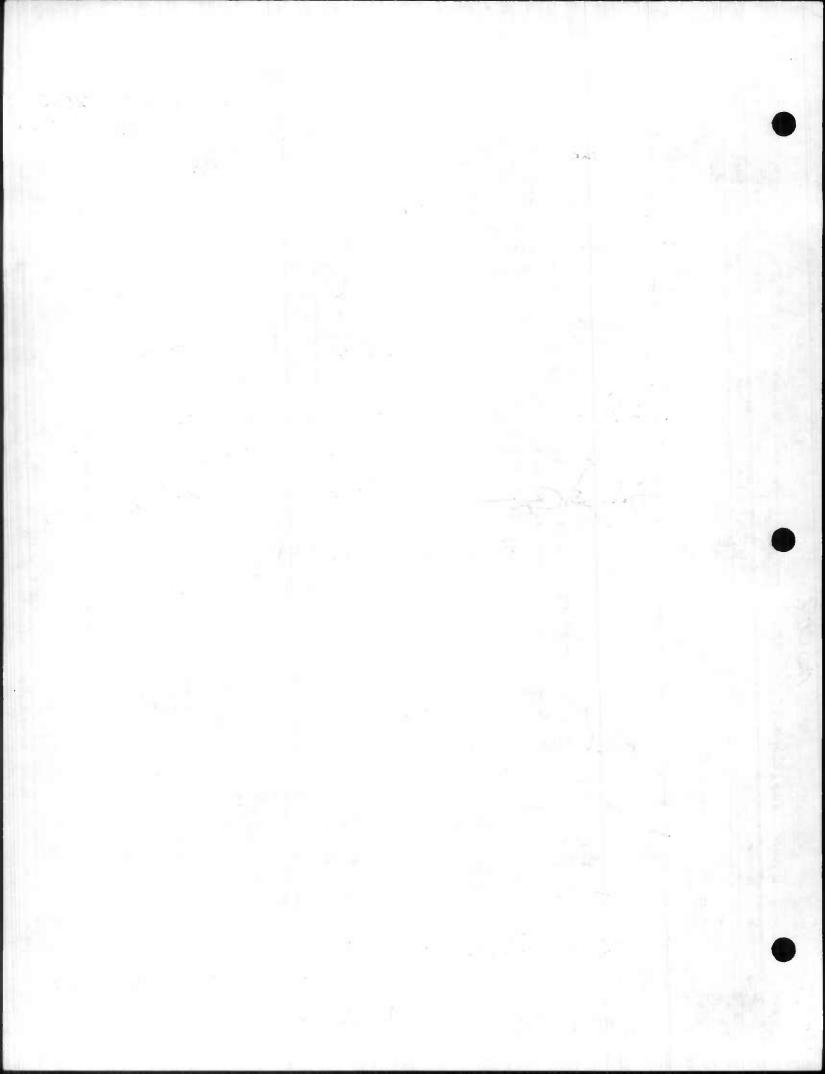
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, Stata 5-18-99 Woodlawn, Maryland King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 22. Nama and Addrass of Facility Vice Licenses 22. Nama and Addrass of Facility

Caple Funeral Service

5502 Winner Ave. Balto., Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximata** Interval Between Onset and Death Physician Probable acute Myocardial
Due to (or as a consequence of): /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Metastatic Carcinon Deen page 2 s LLING 1 Vas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certification by the funeral director, 25. Was case referred to medical examiner?

1 Yas 2 No Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and dua to tha cause(s) and mannar as stated. edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier DOUSY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) salto MD 31. Data filed (Month, Day, Year) 32. Registrar'a Signatura State Registrar ineval **DHMH 16 Rev 6/95**

ORIGINAL

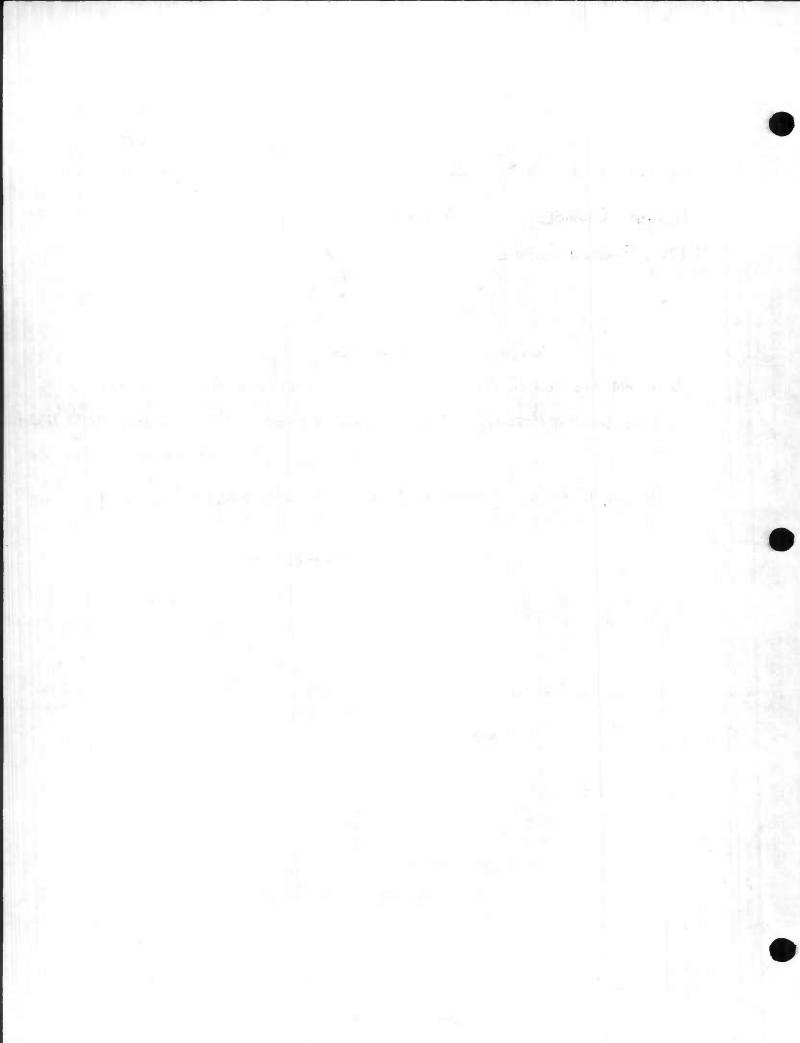


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271	19-510		State of Maryland / Dep	partment of I ertificate of			iene og. No. 99	156	94		
	Physician /Medical	A	1. Decedent's Nema (First, Middla, Last) CARLIE DOVELLE HALL					Dete of Death Month Day Year AAY 11, 1999 1635 PM			
	Examiner	4e Facility Neme (If not institution, give 4405 RASPE AVENUE			4b. City, Town, or Lo BALT IMORE						
th with the Maryland 23e or 28e-f show	Funeral Director	261-60-2043	x 7. Age (In yrs. last birthda M 2≅F 86 Yrs.	y) If Under 1 Year Months Deys		8. Date of Birth (Month, Day, MARCH	Year) 8,1913	9. Birthplace (Sta Country) VIRGINI			
	Maryland of show fled.st	Usuel Residence of Decedent 10a. Stata 10b. County FLORIDA ORANGE			,		e City Limits				
	th with the Ma 23e or 28e-f unt be notifie al Directo	100. Street and Number	19		10g. Citizen of What Country? UNITED STATES						
020	hours after death urst', or items 23 at Examiner must d by Funeral	11. Maritel Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedant Ever in U,S. Armed Forces? 1	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spe pan, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	Black	- American Indian White, etc. WHITE	1,		
	ad within 72 ho ygiene. Ner then "neturn 4, the Medical E Completed	15. Decedent's Edu (Specify only highast grad Elementary/Secondery (0-12)	pation during most of working d)	ng	16b. Kind of Bus		- (1)				
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75.75	Health and 2 sho tem 27 is ma other traums	19e. Informent's Name/Reletionship (T) CECILE LORRAINE (20e. Method of Disposition	BOESCHE/SISTER 271	7 BERWIC	t and Number or Rura	/BALTI	MORE, M				
Baltimore	mit. Pages partment of portant: it it y injury or cs.	1 Burial 2 □ Cremetion 3	GLEN HA		RIAL PARK M						
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	Physician /Medical Examiner	shock, or heart teilure. List only or Immediete Ceuse (Finel disease or condition resulting in deeth)	a. Arteriosclerotic Due to (or es e cons		cular Dise	ease		Intervel	Between ind Death		
. 68760,	certificate be executed viging physician and use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last	Due to (or as e cons								
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Ś	been signe should be d					24a. Wes as perform	n autopsy ned?	24b. Were autop available pr completion of death?	rior to		
	certificate has b rector, page 2 s	25. Was case referred to medical exeminer?		26. Place of Deeth	INSPECTION of death? 1 Yes 2 No 1 Yes 2 No						
of	T die	12 Yes 2 No 27. Menner of Death 12 Veturel 5 Panding 2 Accident Investigation	Hospitel: 1 Inpatient 2 ER/Outpati 28a. Dete of Injury (Month, Dey Year) 28b. Time Injury	of 28c. tnju		na 5 Reside 28d. Describe ho		r (Specify) AT	SCENE		
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	within 24 hours a Lo the Funeral Completely filled	(Check only one) 2 Medical Examination	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	investigation, in my	opinion, death occurre	ed at the time, da	ate end place, a	nd due to the cau			
	N N	29b. Signature and titla of certifiar	1 Chuten	29c. Licen		29	9d. Dete signed MAY 12	(Month, Day, Yea	ir)		
	State	30. Name and eddress of person who co	32. Registrer's Signeture	n Street,	Baltimore	e, Maryl	and 212	01			
	Registrar	MAY 1 4 19	999 1 pera	1. Spar	6						

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth Day 9:15 pm Dorothy Harris Mas 1999 10 4b. Qity, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Hospital Hopkins Baltimore John If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 7. Aga (In yrs. lest birthday 5. Social Security Number 6. Sax Birthplace (Stata or Foraign Country) Months Days 1□ M 3€ F Yrs. 50 213-52-4511 Usual Rasidance of Decedant BALTO. 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits MD N/A 1 XYas 2 No BALTIMORE 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? HADWICK DR. 1435 21221 BAI,TO.

14. Raca - Amaricen Indien, 13. Was Decadant of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuben, Maxican, Puerto Rican, atc.) 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No ff Yas, Giva Yaar or Dates: Black, White, atc. 1 XNever Married 2 Married 1 Yas 2 No BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation 16b. Kind of Businass/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) 12 NURSE PRIVATE DUTY 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Name (First, Middle, Last) EDGAR HARRIS MAUDE GREEN 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Typa, Print) TERRY HARRIS 33 LIBRA CT, BALTIMORE, COUNTY 21237 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 ☐ Cramation 3 ☐ Removal from Stata 5-15-99 BALTO. COUNTY 4 ☐ Donation 5 ☐ Othar (Specify) KING MEMORIAL PARK 22. Name and Address of Fecility eral Service Licenses LEROY O DYETT & SON FUNERAL HOME 4600 I.IBERTY HGHTS AVE, BAILTO. MD 21215 Approximate Interval Batween Onsat and Death Part I. Enter the disease, or complications that clumed the chall. Do not antar shock, or heart failure. List only one cause on each line. fmmadiata Causa (Final diseasa or condition rasulting in death) 5 CKMS Sequentially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) 1mpholytin acule Dua to (or as a consequance of) Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yas 2 ☑ No 2 No 1 ☐ Yes 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mangar of Death 28b. Tima of 28c. Injury at Work? 5 Panding 1 Natural 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida

thet the death certificate be executed Division of Vital Records, P.O. Box 68760, law requires The or Attending Physician: **Physician**

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene. Annut: if teem 27 is marked other than "naturel", or items 23a or 28a-f show any or other traumatic event, if a Heolical Exp. riner must be nottled as

permit. Pages Department of Important: If It any Injury or on

Physician /Medical

Examiner

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Baltimore, Maryland 21215-0020

/Medical

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Funeral

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Certification:

29a, Cartifiar

To the Hospital or Attention 24 hours after des To the Funeral Director completely filled in by the Medical

State Registrar

31. Data filed (Month, Day, Yaar) 1999

Wen-son Hsich

29b. Signatura and titla of certifiar

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mplated causa of death (Itam 23a) (Typa, Print)

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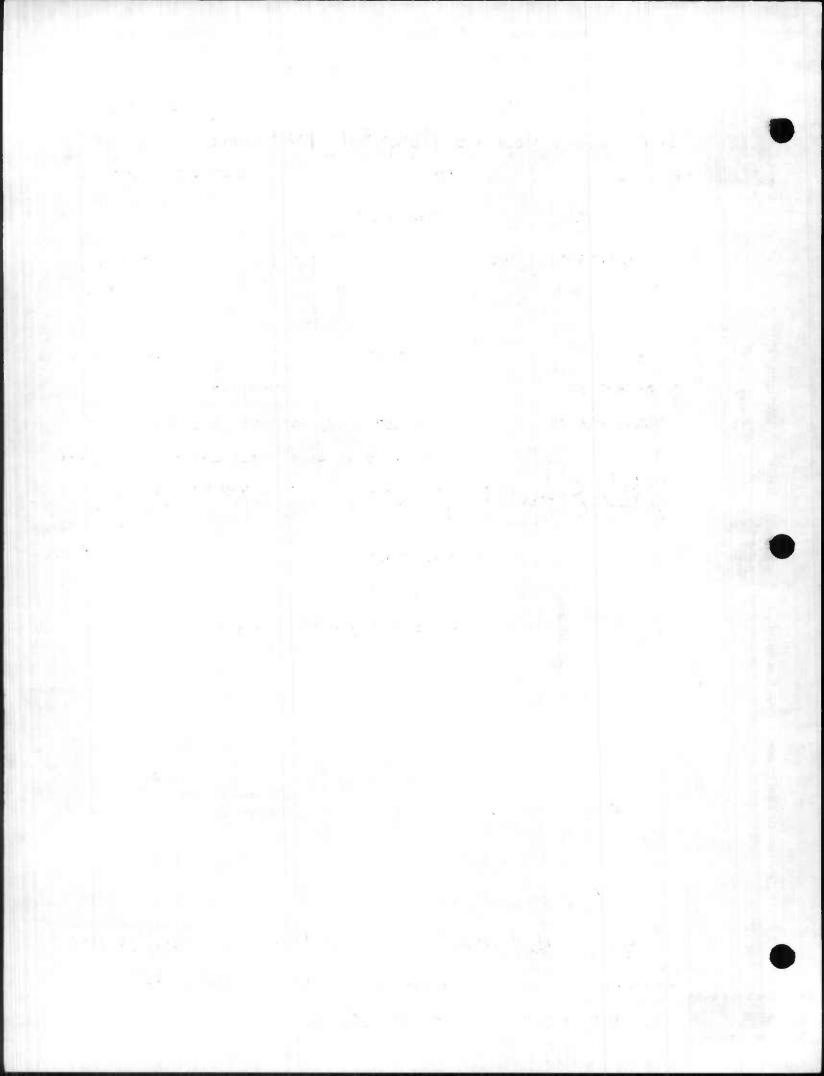
1 Certifying Phyelcfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Data signed (Month, Day, Year)

Baltimore MA



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM#19b PER F.H. G771 5-21-90 J.A. Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4PM **Physician** 1999 SINIG 10 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rulti mac B1/4. noun Hopkins 18 66 V- QW Jo44, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Si Country) June 15,1923 Coeburn, 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8 Sex Birthplace (State or Foreign Country) **Funeral** Months Min. Days Hours 1 M 35F 230-28-7573 75 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7864 Kavanagh Road 21222 United States Funeral death 12. Was Decadent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. filed within 72 hours after 1 Never Married 2K Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pagas I and 2 should be filed within Department of Health and Mental Hygiens important: If Item 27 is marked other than any Injury or other traumetic nother than Eiementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Martha Salina Holbrook Hughie Barron Kennedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7864 1864 Kavanagh Road /Husband Elmer L. Hall, Sr. Dundalk, Maryland 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Temple Hill Cemetery 5/17/1999 Castlewood, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, intervel Between Onset and Death **Physician** Ischemic excephalopathy /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-tran Due to (or as a consequenca of): P.O. Box 68760, physician Physician/Medical the Due to (or as a consequenca of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I detach 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen has 1 🗆 Yes 2 0 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this carific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiper? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2[] No 1 hpatient 2 ER/Outpatient 3 DOA funeral er of Deeth Date of injury (Month, Day Year) 28d. Describe how injury occurred 27. Manj 28b. Time of Certification: Neturel 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of com-29c. License number lan 98010 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Hopkin, Bag vian Mana houming 5 246 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

A146

Registrar

K 530 1 10 To the expension of attention of the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month May 7, 1999 **Physician** Virginia Heller 3:23 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1949 Ewald Avenue Dundalk Baltimore 8. Date of Birth (Month, Dey, Year) 1, 1914 If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Days Months 1 M 2 KF Hours 85 213-16-5508 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-1 show 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 1949 Ewald Avenue Berns 23a 21222 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygien Important if Nem 27 is marked other this any Injury or other free marked other this 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Raymond William Page Mary Virginia Cummings 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Wajbel/Daughter Dundalk, Maryland 1774 Langport Road 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 5/11/1999 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licornice Duda-Ruck Funeral Home of Dundalk, Inc.

Dundalk. Maryland 21222 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Months Examiner Due to (or as a consequence of Examine physicien and s the burial-transit The lew requires that the death certificate be assocuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the the signed by ti 1 Yes 2 No 3 Probably 4 Donknown Š 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: director, 25. Was case reterred to medicet axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After 5 Panding investigation 1 Naturat deeth. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, Records, P.O.

Division of Vital To the Hospna. within 24 hours effer de To the Funeral Direct

State Registrar **DHMH 16 Rev 6/95**

31. Date tiled (Month, Day, Year)

4 D Homicide

(Check only one)

Hac

29b. Signature and title of certified

29a. Certifier

edical

MUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MIL

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ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

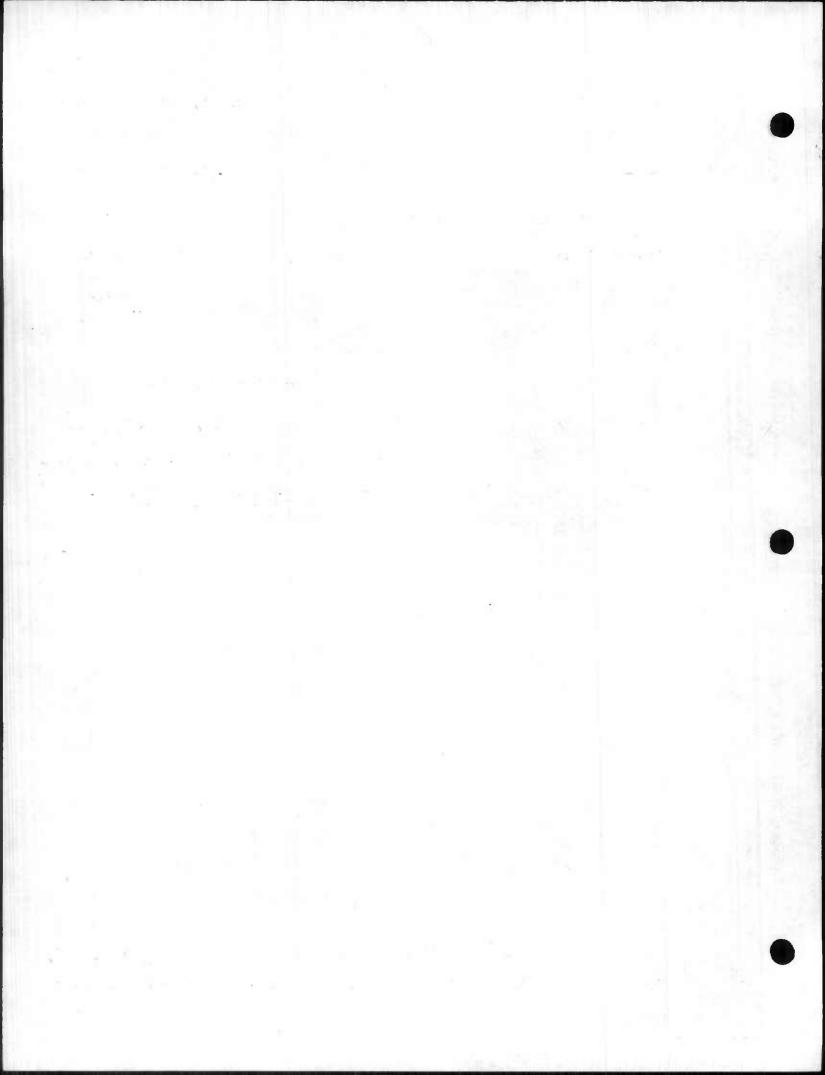
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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29c. License number

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29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Ada 10:15 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deet! Examiner Johns Hopkin Baltimore Bayview Medical Baltimore 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 6. Sax **Funeral** 1 M 2 F Months Deys Min 215-10-8407 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 des 2 No MD Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? "natural", or items 23s or SA 321 by Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes 2 P No If Yes, Give Yeer or Dates: 14. Rece - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 □ Never Merried 2 □ Merried 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) MAKER 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether'e Name (First, Middle, Last) Be ENRICO BERNARD I I LOMENA SARI 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) BALTO. Health a 3 MANGER MD 21237 HRYCEJ 7HEODORE Item 27 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition permit. Pages Department of Important: If its any injury or o Buriel 2 Cremetion 3 Removal from State HILLS 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility RACZOROWSKI 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. AVE or respire Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel heart weeks disease or condition resulting in death) Examiner years Examiner physician and the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) signed by the all d be detached for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cardiomyopathy þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy Completed s certificate has t director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D complataly filled in Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

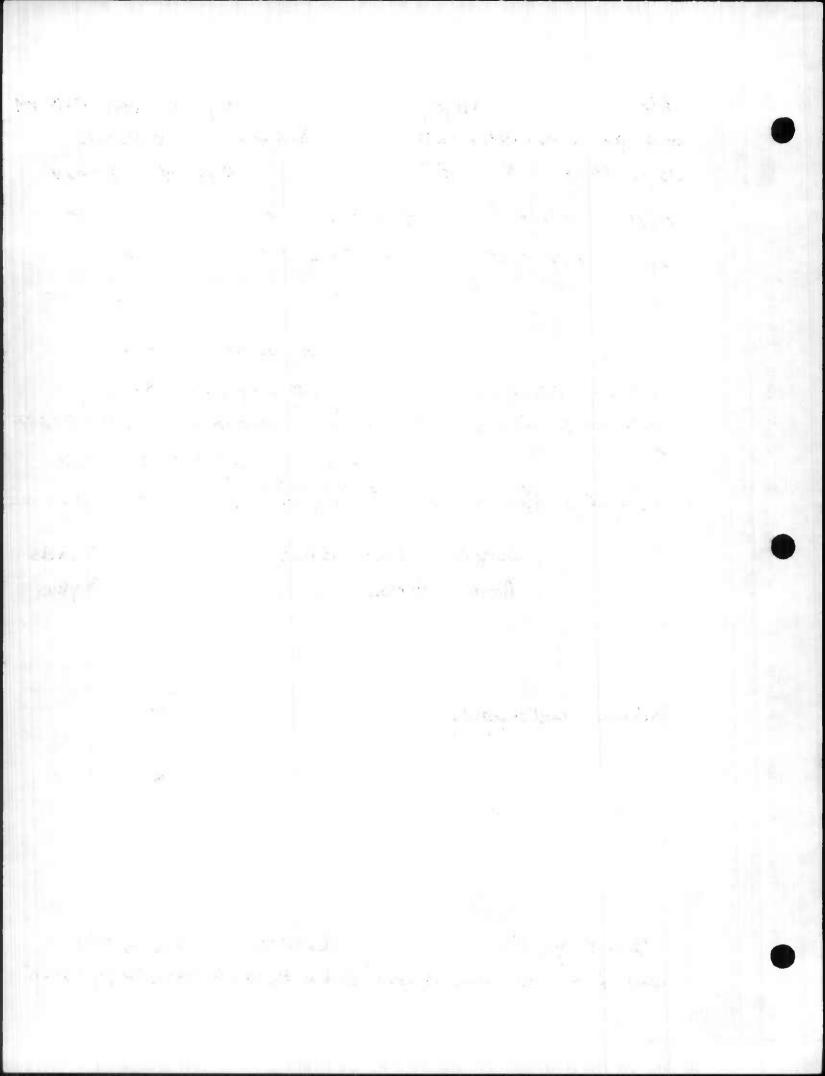
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. edical 29e. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 6, 1999 RES-000 30. Name and address of person w no completed cause of deeth (Item 23e) (Type, Print)

MD, Tower IIO, Johns Hopkins Hospital, Battimore, Maryland 21205 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

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Registrar

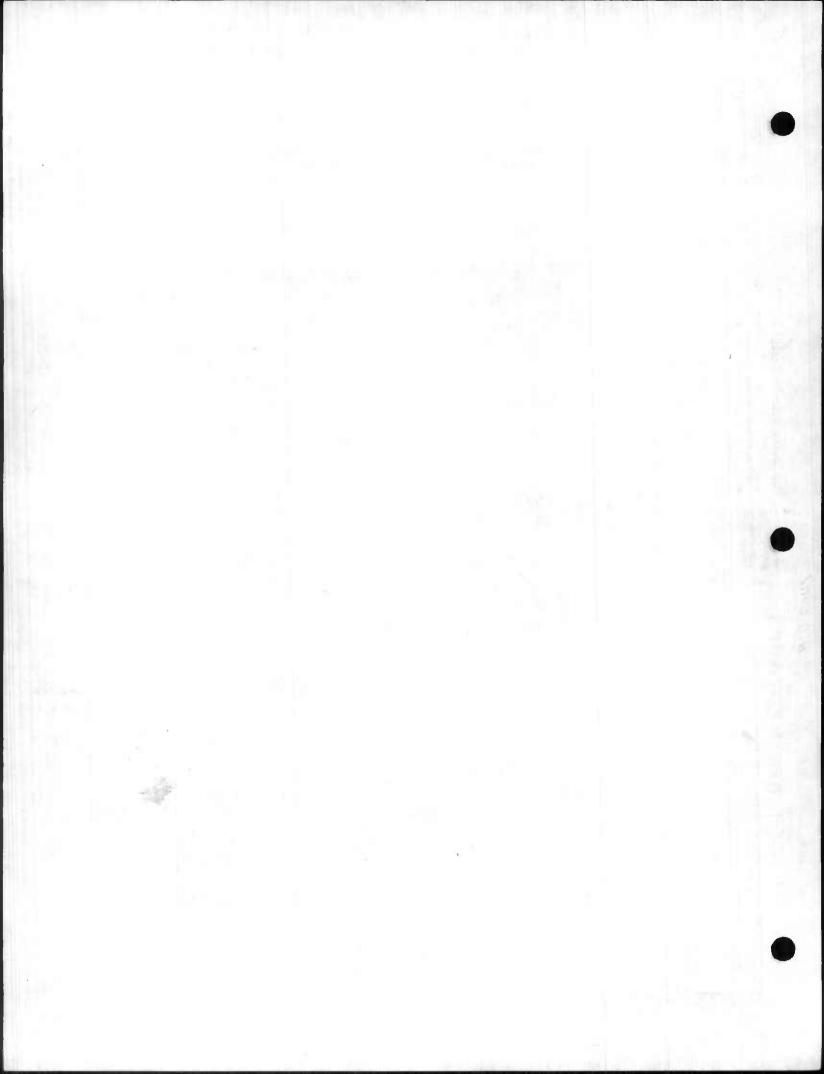
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	State of Maryland / Department of Health Certificate of Death	, ,	00 1000
hysician /Medical	Decedent's Name (First, Middle, Last) BURKHART HENCH		Day Year 5:00 PM
xaminer		own, or Location of Death	4c. County of Death
neral ector	219-26-2983 X M 2 F 64 Yrs. Months Days Hours	MORE 24 Hrs. 8. Date of Birth (Month, Day, Ye Oct 6,1934	
ž w	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
notified at	MD BALTIMORE		1 ☐ No
Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country? USA
	1900 WILLS COURT 11. Marilal Status 12. Wes Decedent Ever in U,S. 13. Wes Decedent of Hispanic O	inin? (Specify Vec or No.	14, Race - American Indian,
by Funeral	Armed Forces? 1 ⚠ Never Merried 2 Merried 3 Wildowed 4 Divorced Armed Forces? 1 ∑ No If Yes, Sive Year or Detes: VIETNAM 1 Yes 2 ∑ No Specify	n, Puerto Rican, etc.)	Black, White, etc. Specify: WHITE
sted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mo	st of working	b. Kind of Business/Industry
Completed	Elemantary/Secondary (0-12) College (1-4or 5+) SHEET METAL ME		MERICAN STANDARD
Be Co		er's Name (First, Middle, Mai	
ToB	NICKOLAUS HENCH LE	OKADIA RUFE	
	19a. Informant's Name/Reletionship (Type, Print) NICKOLAUS HENCH 19b. Mailing Address (Street and Numb 1900 WILLS COURT		
	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donetion 5 Othar (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) OAK LAWN CEMETERY	Date 200 May71999	BALTIMORE , MD
	21. Signeture of Funerel Service Licensee RACZOROWSKI FUNI 1201 DUNDALK AVI	RAL HOME	
be detached for use as the burial-transit by Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in dealth) Lest Due to (or as a consequence of):	21SEASE	10/10
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by Ph	Disbeter Mellitus	1 Yes	25 No 3 Probably 4 Unknow
Completed	DBOSITY	24a. Wes an a performed	
		1 ☐ Yes	2 (2No 1 Yes 25 (No
To Be	examiner: V Hospital:	e of Death (Check only one) ursing Home 5 Residence	a 6 DOther (Specify)
	27. Manner of Death 1. Naturat 5 Pending (Month, Day Year) 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2	28d. Describe how	
Certification:	3 Suicide 4 Homicide 6 Could not be determined 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
edical	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, data e construction of each occurred at the time, data e construction on the data of each occurred at the time, data e construction on the data of each occurred at the time, data e construction on the data of each occurred at the time, data e construction on the data of each occurred at the time, data e construction on the data of each occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data e construction on the data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the time, data occurred at the data occurred at the time, data occurred at the da	nd place, and due to the caus oth occurred at the time, data	e(s) and manner as stated. and place, and due to the cause(s)
M	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)	/	5/6/77
	DEEPAK SETH, 201 WISE AVE, BAUTIM	me, MD.	21757
State	31. Date filed (Month, Day, Year) MAY 1 4 1999 Security 1999		

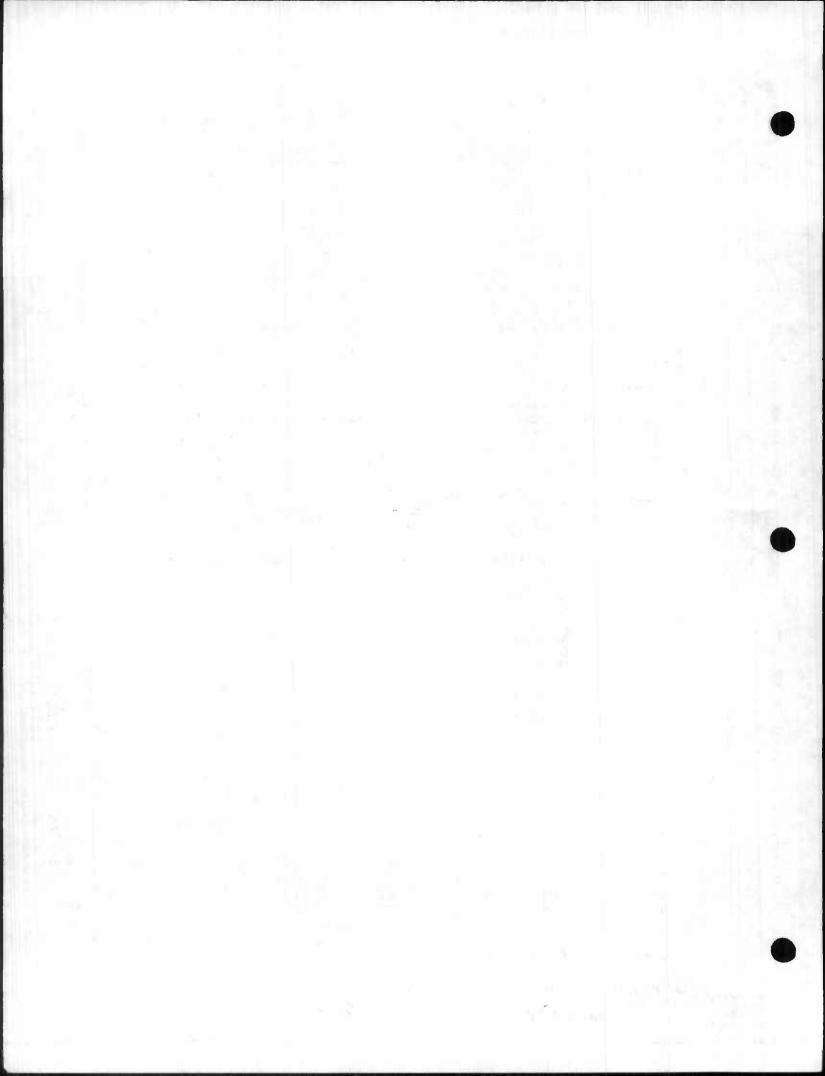
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/Medic Examin		4e Facility Name (If not institution, give 26 SOUTH EXETER S	e street and number) ARTMEN	T 11K		4b. City, Town, or BALTIMOR	Location of Deet	-		
Funeral Director		216-54-4131		ge (In yrs. ld 8		Under 1 Year lonths Deys	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, De 05-29	rth sy, Year) -50	9. Birthpla Countr M I	ace (State or Foreign
Maryland -I show	tor	Usual Residence of Decedent 10a. State 10b. County MD NA			Town or Locati					10	d. Inside City Limits
A 12.13-002.0 d within 72 hours efter deeth with the Manyland d within 72 hours efter deeth with the Manyland of then "partural", or frems 23a or 28a-1 show the Medical Exerciper must be notified at completed by Funeral Director	ral Direc	10e. Street and Number 26 S. Exter S	treet		10f. Zip Code 2120	02		10g. Citizen of Whet Country? USA			
		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces' 1 1 Yes 2 1 fr Yes, Give Yeer or Dates:	?		Decedent of Hes, specify Cub	dispanto Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Special		le.
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should be nd Mental marked o	2	Elmer Ber 19a. tntorment's Name/Relationship (7)	-		19h Mailing A	ddrase /Straat	Louise				Code) 21234
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Icien: The lav		25. Was case reterred to medical					28. Place of Dec	eth (Check only		10	Yes 2 No
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After The state of	Certification:	27. Manner of Death 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be					ry at rk? IYes 2 □ No		how injury occu		
		4 Homicide determined determined 286. Piece of Injury - At nome, term, street, fectory, office building, etc. (Specify)						City or To	(Street and Num		
• Hos 24 hc • Fun letely i	edicai	29a. Certifier (Check only one) 1☐ Certifying Phy (Check only one)	rstcian: To the best iner: On the basis o and menner st	f examineti	nedge, deeth oc on and/or invest	curred et the ti- igetion, in my c	me, date end place opinion, deeth occu	red at the time,	cause(s) and m date end place	enner as sta , and due to	ited. the cause(s)
To the within To the	2	29b. Signeture and title of certifier Atyph	Non	Ne	J, ME	29c. Licens O. C.			29d. Date signo MAY 10		
		30. Neme end address of person who of Strphan S. 1. 31. Dete tiled (Month, Day, Year)	2 adente	3111	Penn St	reet, B	4	, Maryla	and 2120)1	
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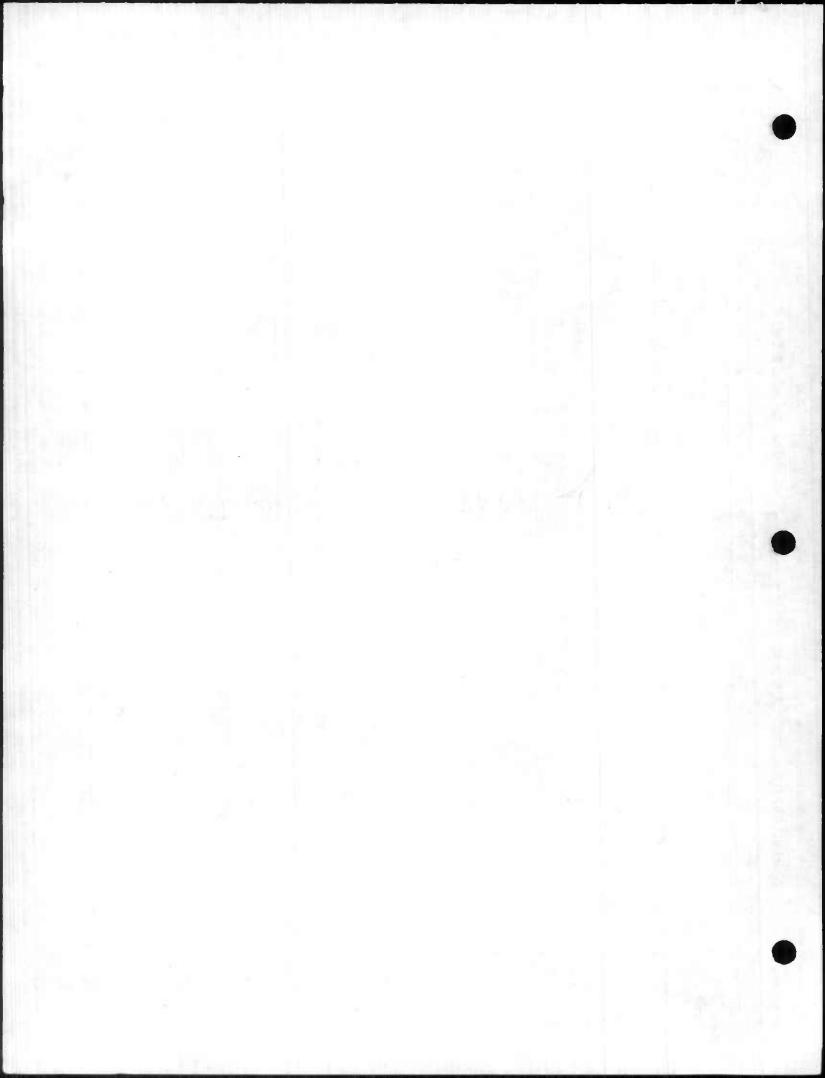


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State of Maryland / Department of Health and Mental Hygiene 99 15701

				Cen	tificate of	Death		R	eg. No.	al I	010	
		1. Decedent's Name (First, Middle, Las	1) 1 101				2	Date of Deal	th Day	Voar	3. Time of U	Death
li.	Physician /Medical	Mary Vira	Ainia John	750n				May	73.	1999	4:50	Am
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, To	wn, or Loca	tion of Death	4c. County	of Death		
		2146 Whistler Ave	2.				imore			N/A		
	Funeral	5. Social Security Number 6. So	DM aXIE		If Under 1 Year Months Days	If Under:	24 Hrs. 8 Min.	Date of Birth (Month, Day)	Year)	9. Birthple Count	ece (Stete or try)	Foreign
н	Director	214-16-8102	76	Yrs.			0	ctober	6,1922	Mar	yland	
	Du B	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation		-			10	d. Inside City	v Limits
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	the h	Maryland N/A	Dal	LCIMOTE	10f. Zip Code			1	Og. Citizen of W	hat Count	IN?	
	with page 10	2146 Whistler Ave				230			United :			
	ther death with the Mar r heme 23a or 28a-f a rive mart be notified Funeral Director	11. Marital Status	12. Was Decedent Ever in U,	S. 13. W	/as Decedent of I		gin? (Speci		14. Race	- America	n Indian,	
50		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 No If Yes, Give		Yes, specify Cub ☐ Yes 2000 No		, Puerto Ri	can, etc.)		white, e		
Maryland 21215-0020	uraf, o	3ÃOWidowed 4 □ Divorced	Year or Dates:	401 David							2	
15-	ed within 72 ho ygiene. The transfer It, the transfer	15. Decedent's Ed (Specify only highest grad	de completed)	(Give k	ent's Usual Occup aind of work done O NOT use retire	du <i>n</i> ng most di	t of working		16b. Kind of Bu	3iness/ind	ustry	
112	d withir piene. r than the k	Elementery/Secondary (0-12)	College (1-4or 5+)		duction	-,			Mani	ufact	uring	
D	be filed ather event, the CC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle, I	Maiden Surname		uz zing	
lan	Vade m	Ferdinand Joseph	Snyder			Ali	ce Vi	roinia	Jorden			
ary.	d 2 should be the end Mental T is marked traumatic every traumatic every traumatic every traumatic every traumatic every traumatic every traumatic every traumatic every traumatic every traumatic every traumatic every tra	19a. Informant's Name/Relationship (7		19b. Mailing	Address (Street					State, Zip	Code)	
	4 4 2 4	Robert M. Nally		2716	Yarnall	Rd. B	altim	ore,Ma	ryland	21227	,	
re,	-755	20a. Method of Disposition		lace of Dispos	ition (Name of atory or other pla	ce)	1	Date	20c. Location - (City or To	wn, State	
Baltimore,	Pages nent of I int: If he iny or or	1 ABurial 2 Cremation 3 4 Donation 5 Qther (Specify	Hemoval from State		e Memor:		rk 5/	17/99	Baltimo	re,Ma	ryland	d
alti	permit. Page Department (important: If any injury of page.	21. Signature of Funeral Service Licen	100	22.	Name and Addre	ess of Facilit	y II am a	of T =	1			20.
œ	Ped Pres	1 NOON TO	-A MACH		19 Hammo						brefve	2122
		23a. Part1. Enter the disease, or composhock, or heart failure. List only	plications that caused the death	Do not ente	r the mode of dyi	ng, such as	cardiac or I	espiratory arr	est,	5,1101	Approximate Interval Betw	
	Physician	and, or heart failure. Elst only t	/							1	Onset and D	eath
4	/Medical	Immediate Cause (Final disease or condition	lunu	1 Can	1000						140	DAY
н	Examiner	resulting in death)		as a consequ						į	1	,,,,,
-	ficate be executed physician and is the bunal-transit edical Examiner	1 1931								1	V	
	eath certificate be executed attending physician and for use as the bunkl-transit clan/Medical Examir	Sequentially list conditions,	Due to (or	r es a consequ	ence of):					1		
60,	cian burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c									
68760,	physic the cate	that initiated events resulting in death) Last	Due to (or	as a consequ	ence of):					1		
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Вох	death e atten ed for u		•					1				
P.O.	that the death of ed by the attend detached for us	Part II. Other eignificant conditions co	entributing to death but not resu	alting In the un	derlying cause gr	ven in Part I.			obacco uas con	44		
		Chronie obstr	uctive puln	nunar	y a1	seasi	2	101	'ss 2□ No	3 Prob	еыу 400	Unknown
of Vital Records,	been sign should be		U		1			24a. Was e	n eutopsy	24b. We	re autopsy tie	ndings
000	es been 2 shoul							perform	mear	con	npletion of ca	
Re	The law requin cate hes been si page 2 should Completed							1 🗆 Y	es 2 No]Yes 2□1	No
ta	certificate rector, pag	25. Was case referred to medical				26 Place	of Death /	Check only on				
>	Physician: The is this certificate he ral director, page ral De Com	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA OH	her-		12	ence 6 Othe	er (Specify	()	
	er this seral di	27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		-		ow injury occurr			
0	Attending In death. octor: After by the fune. Iffication	1 Natural 5 Pending 2 Accident investigation		IIIJUTY		Yes 2 🗆	No					
Division	lat or Attending P rs after death. al Director: After ti ed in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injury - At ho building, etc. (Specify		et, factory, office		28	Location (Si City or Town	treet and Numbern, State)	or Aura	Route Numb	ber,
	pptal or Attending Phens after death. orn Director: After thiffled in by the funeral all Certification: 7		John Mary Con (Speeding	,					, , ,			
	8424 D	29a. Certifier (Check only one)	reiclan: To the best of my know iner: On the basis of examination and menner steted.	wiedge, deeth ion and/or inve	occurred at the ti estigetion, in my	me, dete en opinion, deel	d place, en th occurred	d due to the c et the time, d	ause(s) and mailete end plece, a	nner as stand due to	ated. the cause(s)	
	Med Med	29b. Singature and title of certifier	one memer stetes.	-	29c. Licen	se number		2	9d. Date signed	(Month, I	Day, Year)	
	1/0	Wedney Well	w. Mo.		DA	1754	40	6	May 1	3,	1999	
1	No	30.Nama and address of person who o	ompleted cause of death (Item	23a) (Type, P	Print)		1	, 5	"	/		
	7	Kelma Miller, N	D Room 719	13 J	toC, 60	1 Ni	Caroli	ne Ba	Hinore	MD	2/2	31
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	lure	1	/	,					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month Goldie MA Facility Nama (If not institution, give street and number, Town, or Location of Deal MillerSVi erunda 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□ M 20 F Hours mary lana Yrs. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizan of What Country? 10f. Zip Coda 127 . Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Datas: 14. Race - American Indian, Black, Whita, etc. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 17. Fathar's Name (First, Middle, Last)
Tom Brooks 19a. Informant's Name/Relationship (Type, Print) rel Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Laves 23a Part. Enter the diamete, or complications that caused the death. Do not back, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24e. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 27. Menner of Death 1 Denatural 2 Accident

Physician /Medical **Examiner**

The law requires that the death certificete be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

After this

deeth.

Physician

/Medical

Completed by Funeral Director

Be

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene. Important: if fem 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Machinal Essent.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Medical Certification: To

use es the buriel-transit filled in by the funeral director, page 2 should be detached signed by Be Completed by certificate has To the Hospital or Attendi within 24 hours effer deeth. To the Funeral Director: A

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 🗌 Yes 28d. Describe how injury occurred

Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a, Certifier

3 Suicida

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceusa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier,

D21684

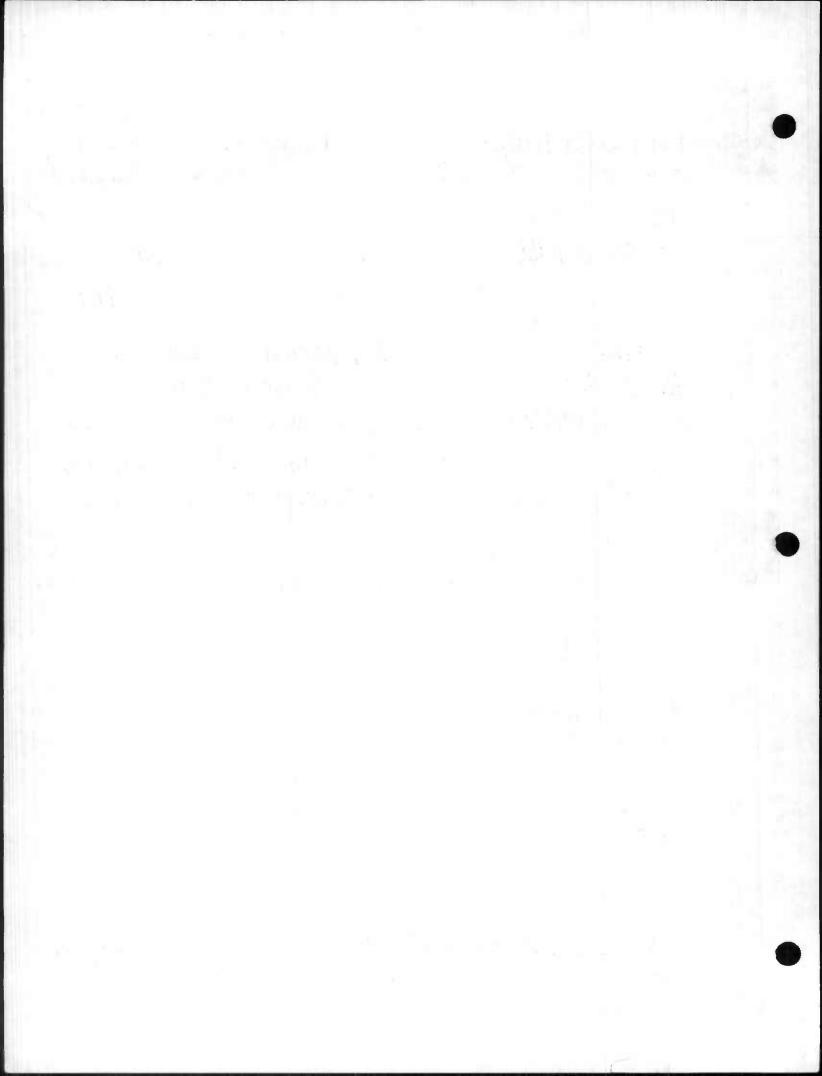
em 23a) (Type, Print) COWY, PASADENA, 30. Name and eddress of person who comp 8109

State Registrar 31. Date filed (Month, Day, Year) MAY 1 4

5 Pending Investigation

6 Could not be determined

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** :15A May 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Home Bartimore
If Under 1 Year If Under 24 Hrs. 8. Dete of NA onc Nursing 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1□ M 2√ F Months Days Hours Min. 215-30-0835 Yrs. 86 VÁ 07-22-12 Usual Residenca of Decadent 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Baltimore NA MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 1215 N. Curley Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ★ TNo If Yes, Give Year or Dates: 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black þ 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) in & out of home 8th Grade NA Days work 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Julia Newby Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5306 Midwood Avenue Baltimore, MD Robert Keys 20b. Piace of Disposition (Neme of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State M Buriai 2 ☐ Cremation 3 ☐ Be moval from State Baltimore Cemetery 05-17-99 Baltimore, MD 4 □ Denation 5 □ Other (Speed 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signelly of Funeral Servica WM.C.March FH 1101 E. North Avenue ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Tangrene Immediate Cause (Final weeks disease or condition resulting in deeth) Examiner reripheal eas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Ø No 3 Probably 4 Unknown Stroke p Diabetes Mellitus 24b. Were autopsy findings eveilable prior to Completed 24a. Was an autopsy completion of cause of death? 1 Yes 2) No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier Textifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice stely filled in by the funeral director, To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the

Funeral

Director

th and Mental Hygiene.
7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 ahould be filed within 72 hours after deat.
Department of Nesth and Mental Hygiene.
Important if filem 27 is marked other inany injury or other traumants.

Physician

/Medical

Examiner

ettending physician end for use as the burlal-transit

signed by the e

is certificete has but director, pege 2 s

The Marylan

State Registrar

29b. Signature and title of certifier

30. Name and address

31. Date filed (Month, Day, Year) MAY 1 4 1999

SchWARTZ

165 M.D 32 Registrar's Signature

Attendina

reducal

who completed cause of death (Item 23a) (Type, Print)

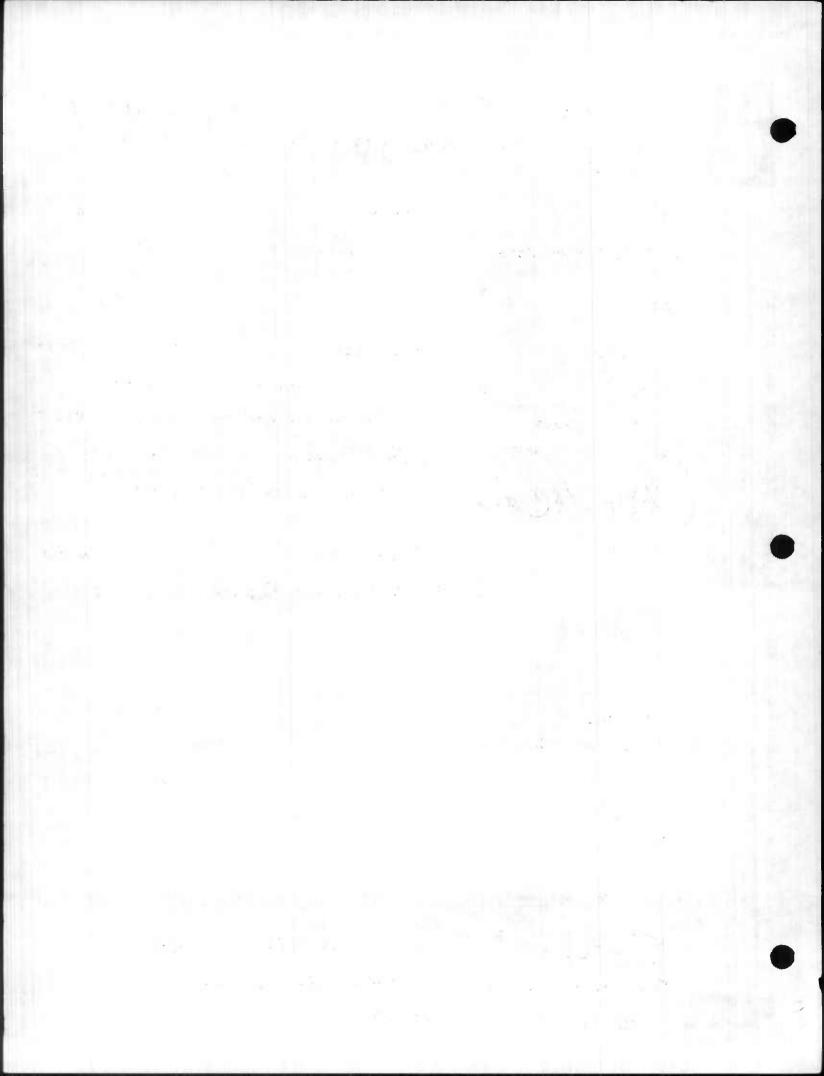
E. MelRose Ave

29c. License number

D17118

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 13, May Mildred Amelia Keene 11:21 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 617 Maryland Avenue Essex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Euneral** Days Hours 1 M 2 DOF Months 219-05-0159 Director 79 Feb. 02, 1920 Maryland Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 617 Maryland Avenue U.S.A. 21221 "natural", or flams 23s 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Stetus Bleck, White, etc. atte 1 Yes 2X No if Yes, Give Year or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2℃No Specify: Specify: White à 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygen Important; if hem 27 is marked other th any injury or other the marked other th Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Josephine Strand George Meyer 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 617 Maryland Avenue, Baltimore, Maryland 21221 Frederick M. Keene, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete ₩ Buriai 2 Cremetion 3 Removei from Stete Gardens Of Faith Cemetery 5/15/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensu 22. Name end Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that edused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Box 68760 Physician/Medical Due to (or as e consequence of) ò P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? peed completion of cause of death? 1 Yes 200 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death.

Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di Jetely filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Daniel

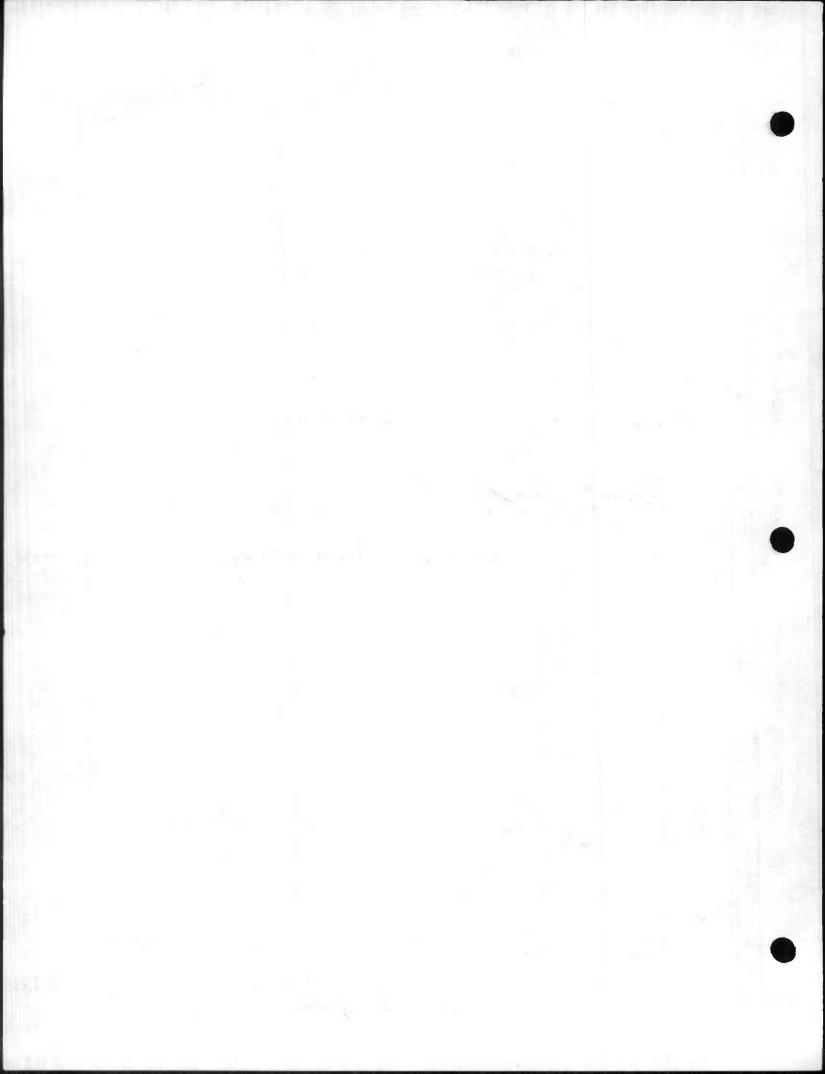
31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

MANERS

32. Registra's Signeture

9000 Frunklin Square Dr. Bult, MD 21337



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienen

Item: 8, per Informant G-771 5/14/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month May 08 1999 1:15AM Isaac S. Kershner /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth 1929 (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days Hours 10 M 2□ F 69 **Director** 045-20-8923 Conn. Usuet Residence of Decedent with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "naturel", or itema 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2806 Taney Road U.S.A.

14. Race - American Indian,
Bleck, White, etc. Funeral 21209 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Kershner, 1500 Peges 1 end 2 should be filed within 72 hours after nent of Health and Mentel Hygiene. 1 XYes 2 No if Yes, Give Year or Dates: 1947-50 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Law Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mollie Goldstein David Kershner 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 I Ingrid Kershner/wife 2806 Taney Road, Baltimore, MD 21209 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature o Funeral Servica Licansee 22. Name and Address of Facility Ronald S. Wade, Director

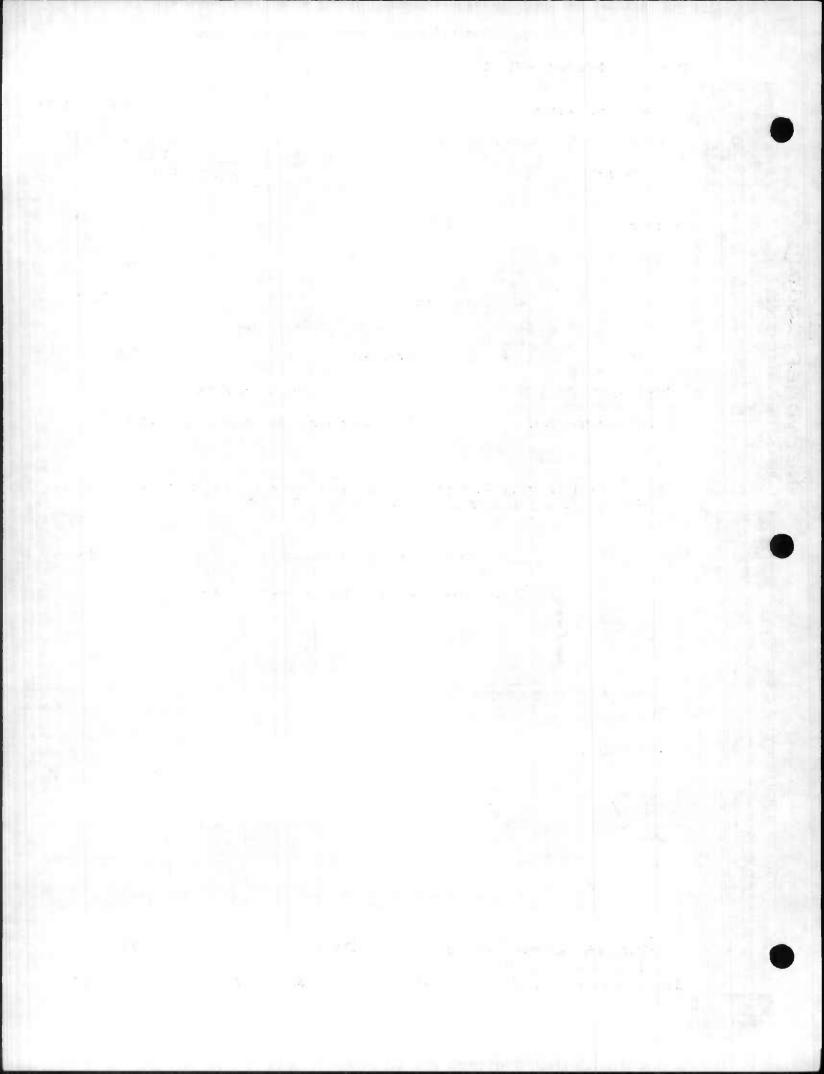
Ronald S. Wade, Director

State Anatomy Board, 655 W.

Baltimore, MD 21201

23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. State Anatomy Board, 655 W. Baltimore Street Approximate tritervat Between Onset and Death Physician immediate Cause (Final disease or condition resulting in deeth) /Medical a. Cong Estive 116AcT

Due to (or es e consequence of): 3moul1 **Examiner** Examiner DISCASC D. PHIGNOSCLMOTIL CARDIOUASCULAR physician and the bunel-trensit certificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 80 USB ed by the e 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown DIRSCTUS signed b à 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed PUGUMONIA hes page 2 2 1 No 1 ☐ Yes 2 € No certificate or Attending Physician: funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 28a. Date of fnjury (Month, Day Year) 27. Menner of Death 28c. injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of Naturai 5 Pending efter death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Hospital 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner steted. within 2 100 29c. License number 29d. Date signed (Month, Dey, Year) 0 Golde HENLES MA D33011 30. Name and eddress of person who completed/cause of death (Item 23a) (Type, Print) \$ 346 PAPERMICE PHOGNIX Mel 2113) A WIED (FGCD Red MD 32. Regionar's Signature State Registrar

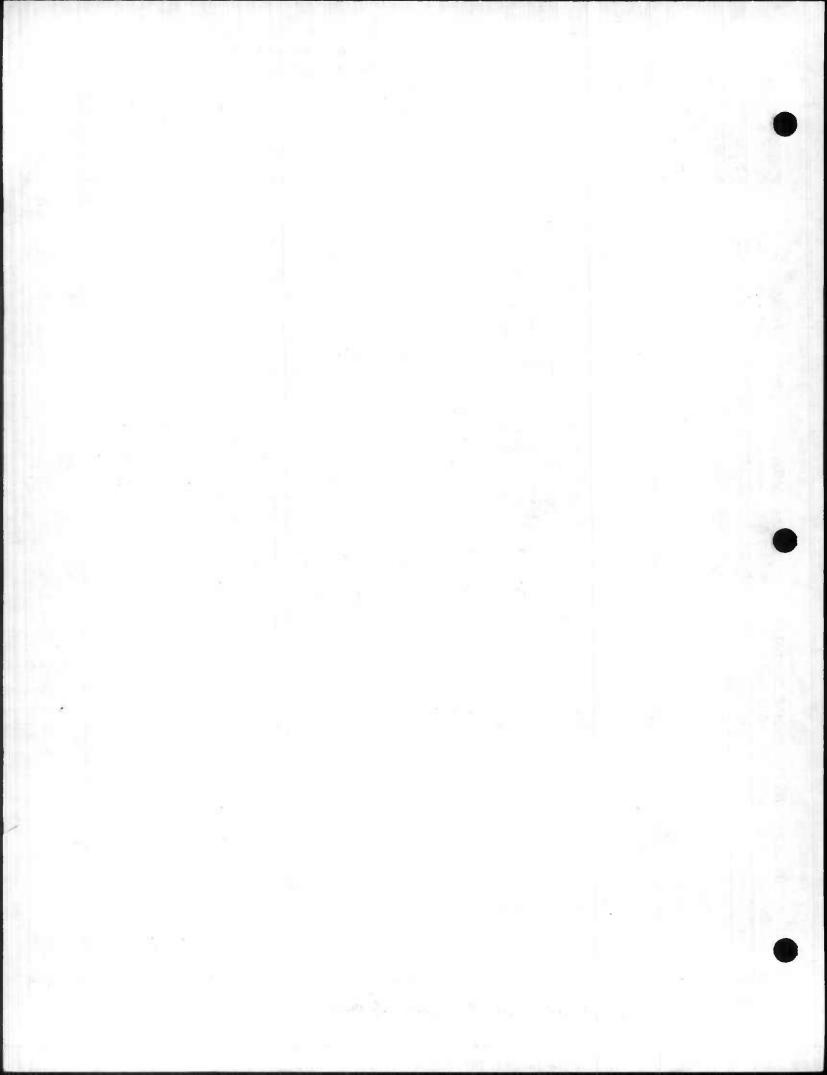


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** KOSZCZEPK DREY 3 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3834 Bank Street Baltimore If Under 24 Hrs. 8. Data of If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Min. 1 ☐ M 2 🖾 F Hours 220.64.5312 87 Director 2-27-1912 W. Virginia Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD n/a Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3834 Bank Street 21224 USA deeth 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indien. 11. Marital Status Black, Whita, etc. filed within 72 hours efter of Hygiens. The matural, or her 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify American Indian 1 Yas 2 No Specify: py 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If fee 27 is marked other tha eny injury or other treumatic event, that once. National Can Co. Inspector 8th 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Benjamin Riggs Molly Blanketship 19a. Informant's Name/Relationship (Type, Printh usband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3834 Bank Street, Baltimore, Maryland Ben Koszczepki 21224 20b. Place of Disposition (Nama of cematary, crematory or other) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ₺ Burial 2 □ Cremation 3 □ Removal from Stata 5/17/99 Oaklawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Joseph N. Zannino Jr. Funeral Hm 21. Signature of Funeral Service Licenses 263 S. Conkling St., Baltimore, Maryland 21224 Maria B. farreno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of): Examine GROTIC DISEASE Examiner physicien end the buriel-transit Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the ed be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown FIRRILLATION Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 : a No 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case refarged to medical examiner?
1 ☐ Yes 8 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Assidence 8 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Deatural deeth. 1 ☐ Yas 2 ☐ No hours efter deeth unerel Director: 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours effer dea To the Funeral Director completely filled in by th 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 11 Corrlying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and part of certifier 29c. License number 29d. Data signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 3411BANKST. BALTO ND 21224 ATHUNGAMMAD 32. Registrar's Signature 31. Data filed (Month, Day, Year) State MAY 1 4 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene O O

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 05 **Physician** John Keitz 8:25 pm 10 /Medical 4b. City, Town, or Location of Daeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Johns Hopkins Bayriew Medical Center Bultimere. N/A 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year 9. Birthplece (State or Foreign 8. Dale of Birth (Month, Dev. Yeer) **Funeral** Months Deys Hours Min 1**X** M 2□ F Maryland 214-22-8576 **Director** Aug. 9, 1925 Usuei Residenca of Decedent the Marylend 10e Slete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Maryland Dundalk 1 Tyes 28 No Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Peges 1 and 2 should be filed within 72 hours effer death with the Department of Heelth and Mental Hygiene.

Important: If item 27 is marked other than "natural, or items 23s or 21 any injury or other traumatic event, the Medical Exercises page. 21222 United States 8441 Kavanagh Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Maritel Stetus 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: WWII White g Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Steel Industry 10 Years Palm Oiler 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Henry Keitz Katherine Trice 10 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1129 Old Eastern Ave. #C Baltimore, Maryland Helen Keitz / Daughter 20c. Location - City or Town, Stete 21221 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) Date 20e. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Mem. Gdns. 5/14/1999 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of unerel Service Licensee 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. Part Enter the please of complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or respiratory arrast,

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Approximate Approximate tritervel Between Onset end Deeth **Physician** Immediate Causa (Final disease or condition rasulting in deeth) /Medical 3 hrs. hypoxemia Examiner Examiner Dneumania physician end the bunal-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseesa or injury that initieted events resulting in deeth) Lest Dua to (or as a consequanca of) that the death certificate be execu P.O. Box 68760, aspirahan Physician/Medical Due to (or es e consequenca of): 88 use 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No renal disease Division of Vital Records, Completed by 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performad? Cardionyopathy completion of cause of daeth? 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
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1 ☐ Yes 2 ☐ Po Be 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, daath occurred et the time, date end plece, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, daeth occurred et the time, date end placa, and due to the ceusa(s) end menner stated. edical 29a. Cartifier (Check only one) To the within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number 5-10-99 agne I domo 983030 30. Name and eddless of person who completed cause of death (Itam 23a) (Type, Print)

Stasia Reynolds, MD 4940 Eac 4940 Eastern Are Baltimore, Maryland

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31. Dete filed (Month, Dey, Yeer)

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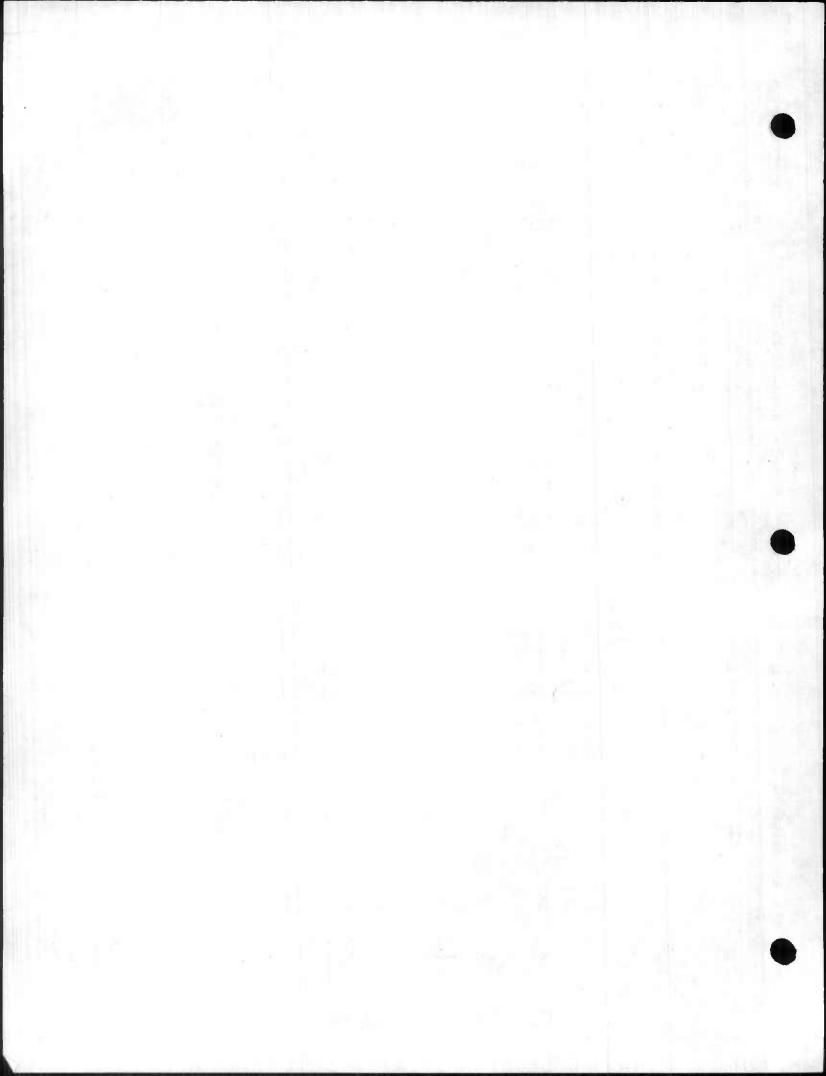
32. Registrer's Signatur

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#1 perPhyG771 5/18/99 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 5:38 AM Un Ha Lee MA 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GEN BURNIE Hospital orth Hrundel If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) March 29,1921 7. Age (In yrs. last birthday) Birthplece (Stete or Foraign Country) 1 □ M 2 🛛 F 623-16-2893 78 Korea Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severn 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1802 Clearwater Court 21144 Korea 12. Was Decedent Ever In U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. 1 Never Marriad 2 Married 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: Specify: Asian 1 ☐ Yes 2(No 3 XWidowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Kyong Yoon Hyun Kannan Lee 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Coda) Ui Sun Hyun (Daughter) 1802 Clearwater Court, Severn, MD 21144 20b. Plece of Disposition (Neme of cematary, crematory or othar place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Spacify) 05/13 Metro Crematory Baltimore, MD 21. Signeture of Funaral Service License 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 alre 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel Anteriosolerotic Heart Disease disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Due to (or es a consequença of):

Physician /Medical **Examiner**

and

permit. Page Department of Important: If any Injury or

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/Medical

Examiner

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Funeral

Completed by

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death nearth Mental Hygiene. ant. if item 27 is marked other than "natural", or Items 23 ury or other traumatic event, the Medical Examplement.

Baltimore, Maryland 21215-0020

with the Maryland

burial-transit the esn nse ate has been signed by the a page 2 should be detached to filled in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Part II. Other significent conditions co		sulting In the underlying ca	use given In Pert f.	23b. Did tobacco use co	ontribute to the cause of death 3 ☐ Probably 4 ☐ Vnknov	
				24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of causa of death? 1 Yes 2 No	
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examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient 2 ☐	FR/Outpetient 3□ DO/	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)	
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State Registrar

31. Dete filed (Month, Day, Yeer) MAY 1 4 1999

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DHMH 16 Rev 6/95

within 24 hours after death. To the Funeral Director: A

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month Helen Langley 11:30 p.m. 10 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 2500 N. Ellamont Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (Steta or Foreign Country) 7. Age (In yrs. last birthday) 1□ M 2⊠ F Months Days Hours Yrs. 71 215-24-3247 S.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NA Md Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2500 N. Ellamont Street 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Barr Salfort College (1-4or 5+) NA Elementary/Secondary (0-12) 11th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Nathaniel Logan Eloise Dowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Nathaniel Dowell - Son N. Ellamont Street Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Memorial Park 5-15-99 Arbutus, Md 22. Name and Address of Facility March F/H Wes 21. Signature of Funerel Service Licenses West Wabash 4300 Avenue Baltimore, Md 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediete Cause (Finel disease or condition resulting in deeth) Fer 105 krotes, Cardiovarela Direne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEART FAILURG 24b. Were eutopsy findings available prior to complation of causa of death? 24a. Was en autopsy performed? cart block Spo 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) 1□ Yes 22 No Other: 4 Nursing Homa Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Neturel 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

The law requires that the death certificate be executed the burial-transit Box 68760. 980 P.0. Records, this certificate has Division of Vital or Attanding Physician: funeral After 24 hours after death.

Funeral Director: A filled in by the Hospital **Sompletary**

Physician

Examiner

Funeral

Director

28e-f

must be n

Pages 1 and 2 should be filed within 72 hours after their of Health and Mental Hygiene.

ant if Nem 27 is marked other than "natural", or he usy or other traumatic event, the Medical Examine

Department of Important: If Important: If Important or Im

Physician /Medical

Examiner

Examiner

Physician/Medical

Medicai Certification: To Be Completed by

29a. Cartifier

(Check only one)

29b. Signature and title of

31. Data filed (Month, Day, Year)

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

ğ

Completed

Registrar

within 2 To the 9

DHMH 16 Rev 6/95

0 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARRISON

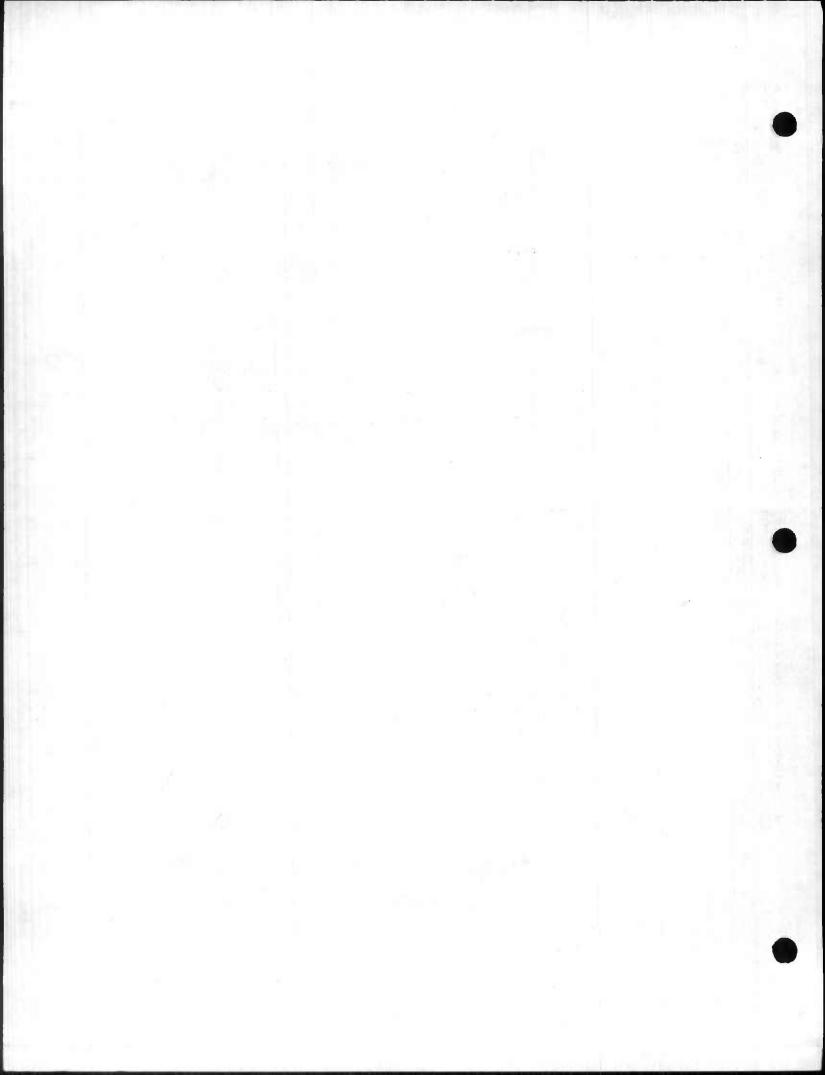


Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29c. License number

Blva



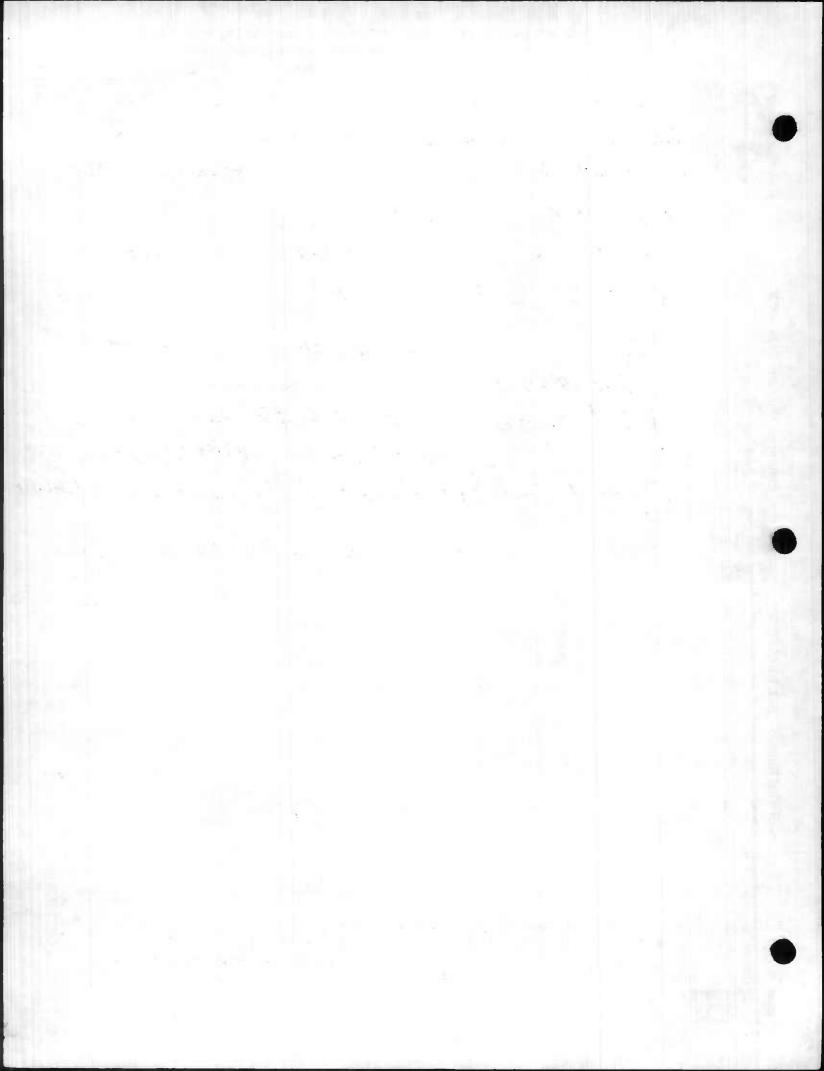
Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death MOSES **Physician** 1.15 AM ALTON Hay /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner Home Balto MARdeN NUTSING If Undar 1 Yaar 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Min - 14-5463 1 M 2□ F Days Hours 215 Yrs. 76 22/22 Director Usual Rasidanca of Decedant with the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at alto 1 XYas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7148. 43 nd 2/2/8 U157 permit. Pages 1 and 2 should be filed within 72 hours eftar death 1 Department of Health and Mahala Hygiens. Important: if flem 27 is marked other than "naturel", or items 23s any Injury or other traumatic avant Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status ☐ Yas 2 No Yes, Giva 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 HNo Specify: Blest Specify: Şq 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Driver Gth 18. Mothar's Nama (First, Middle, Maidan Surnama) 17. Fathar's Nama (First, Middle, Last) MOSES Unknows 19a. Informant's Name/Relationship (Typa, Print) 19b. Maiting Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Balto 10 20b. Place of Disposition (Name of camatery, cramatory or other p 20a. Mathod of Disposition Date 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) LION Cem 22. Nama and Addrass of Facility 21. Signatura of Funarat Sarvica Licensaa beks Enter the disease, or complications that caused the death, or heart fallure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Examiner ettending physician and for use as the bunal-tran-Sequentially list conditions, if any, laading to Immadiata ceusa. Enter Undarfying Causa (Disease or Injury that initiated avants rasulting In death) Last Dua to (or as a consequence of) that the death cartificete be axed Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): as signed by tha e 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 4 Unknown 1 Yes 2 No 3 Probably Completed by 24b. Wera autopsy findings available prior to complation of cause ot death? 24a. Was an autopsy peeu has 2 No 1 Yes 2 No cartificata Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this cartifice director, 25. Was cesa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient 28a. Data of Injury (Month, Day Year) funeral 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? Certification: 1 Naturat
2 Accident 5 Panding Invastigation 1 ☐ Yas 2 No 6 Could not be datarmined 3 Suicida 28e. Ptace of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida Two certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or treastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medicai completely (Check only one) To the F within 2 29b. Signature and title of certifler 29d. Data signad (Month, Day, Year) 29c. Licensa number marchi 3066 30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print) 312555 H Harboronce Numburg Home Baltimore TRIPURANENI -2121 Kol

State Registrar 31. Date filed (Month, Pay Year) MAY 1 4 1999 32. Registrar's Signature

Sports



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Dev Year **Physician** GLORIA MILLER 9:30 PM MAY 1999 10 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE CITY MANY LAND OF UNIVERSITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Hours 65 Yrs. 213-30-0462 Director DEC.7, 1933 MARYLAND Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Nems 23a or 28a-f ahow traumatic event, the Medical Examiner must be motified at 1 Yes 2 No Directo ANNE ARUNDEL GLEN BURNIE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6 HARRIET DRIVE 21060 U.S.A. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 242 No
If Yes, Give
Year or Dates; Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by X□ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) i Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) . Peges 1 end 2 should be filed will ment of Health and Mental Hygien tant: If item 27 is marked other the jury or other traumatic event, Ital. 12 HOMEMAKER OWN HOME 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be GINTO MARTELLO CLEMS MARY GAFFONIA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) LISA A. RICHARDSON 35 BELMORE ROAD, LUTHERVILLE, MD. (DAUGHTER) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b Place of Disposition (Nama of 20c. Location - City or Town, State cematary, cramatory or other placa) permit. Pege Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) VETERANS CEMETERY 5/13/99 CROWNSVILLE, MARYLAND 21. Signature of Poneral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 eimplement ons that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Causa (Final NOUTE LYMPHOLYTIC LEUKEMIA, RELAPSED disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician and the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 nse ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? deteched signed by t 1 Yes 2 No 3 Probably 4 Unknown Emphysima SEVERE þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attanding Physician: director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 ⅓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident To the Hospital or Atta within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edical 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and piece, and due to the cause(s) and manner staffed. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DW MAT 10, 1999 P11769 (Item 23e) (Type, Print) 30. Name and address of person to compare JOSEPH LONGHITANO, MD BALTIMONE mANTLAND) S. Greene St MD 21207 UNIVERSITY

15 44

DHMH 16 Rev 6/95

State Registrar 31. Dete tiled (Month, Day, Yaar)

MAY 1 4 1999

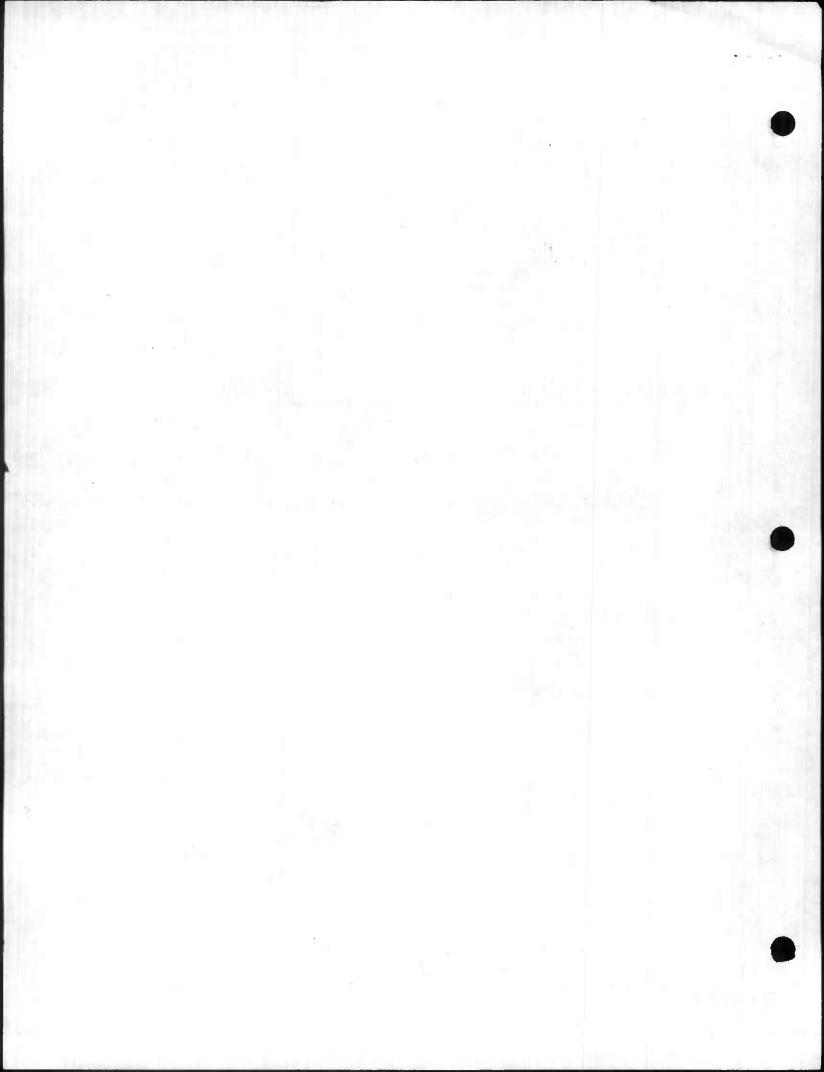
32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 15AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner sedale Woods If Under 1 Year If Under 24 Hrs. 9. Birthplace (Stata or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months 681 Yrs. Director 16-Usual Rasidance of Decedant deeth with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, atc.) Rems 2 Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
nt: If Item 27 Is marked other than "natural", or its 1 ☐ Yas 2 No If Yas, Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or White 1□ Yes 21 No Specify: by Yas, Gran Yaar or Datas: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 0 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be heeborah OP 2 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) : If Item 27 Is n 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata matary, crematory or other place 1 Burial 2 Cramation 3 Removal from Stata Department in Important: If any injury or 4 □ Donation 5 □ Othar (Specify) Dermit. 22. Name and Addrass of Facility 21. Signature of Furieral Service Licenses Evans Funeral Chas 23a. Part1. Entar tha disaasa, or complications that caused tha daath. shock, or haart failura. List only ona causa on each lina. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence Examiner rovascu or Attending Physician: The law requires that the deeth certificate be executed the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): USB 85 signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records. Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? should page 2 2 No certificate 1 Yas 2 19 No 1 Yas Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 2 No Certification: To 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Natural 5 Panding invastigation after deeth. 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Illed in by 4 Homicida 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the 1 å 29b. Signature and title of certifie 29d. Data signed (Month, Day, Year) 2 th (Item 26a) (Type, Print) Pay 399 32.(Régistrar's Signatura State 4 Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Neme (First, Middla, Last) Month May 4c. County of Death 4h. City. Town, or Location of Dualin 4a Facility Nama (If not institution, give street and number) entel If Under 1 Year 6. Sax 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Deys Hours Min 1□M 200 F 86 Yrs. June 5 New Usual Rasidance of Dacedant 10a Steta 10b. County 10c. City, Town or Location 10d. Insida City Limite 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Hollow 21234 Man 110 Was Dacedant Evar in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva Year or Datas: 14. Race - American Indian, Black, Whita, atc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Naver Married 2 Married 1□ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Dacedant's Education (Specify only highest grada completed) 16a. Dacedant's Usual Occupation (Giva kind of work dona during lifa. DO NOT usa ratired) 16b. Kind of Business/Industry ring most of working Elamantery/Secondary (0-12) Collage (1-4or 5+) 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mark Miller 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata May 18 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 □ Donation 5 □ Othar (Specify) 21. Signature of Furerai Sarvida License 22. Nama and Addrass of Facility vans 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Md 21234 Approximata Interval Batween Onsat and Death Concer Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consaquance of) Sequantially list conditions, if eny, leading to immediate causa. Entar Undarlying Causa (Diseasa or Injury that initieted events rasulting in daath) Lest Due to (or as a consaguance of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Wes an autopsy performed? complation of causa of death? 1 ☐ Yes 2 ☐ No 28. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Residence 8 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA TOSPICE 27. Mannar of Death 1 (ONatural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury al Work? 5 Pending invastigation 1 Yas 2 No 2 Accidant 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

2 signed by 2 # ò To the Hospital of within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Directo

Funeral

À

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other fraumatic event, if a Men

Physician

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Physician/Medical Examiner

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Certification:

Medical

the Manyland

25. Was casa rafarred to medical axaminar?

1 Yas 2 No

3 Suicida 6 Could not be determined 4 Homicide

281. Location (Street and Number or Rural Routa Number, City or Town, State)

29a, Certifier

The Certifying Physicien: To the bast of my knowledge, daath occurred at tha tima, data and place, and dua to the cause(s) and manner es stated.

2 Medical Examinar: On the bast of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signetura end title of Artific

rass of person who complated causi

29c. Ligansa number

Bulto. Md 2120x

29d. Deta signed (Month, Day, Year)

GBMC

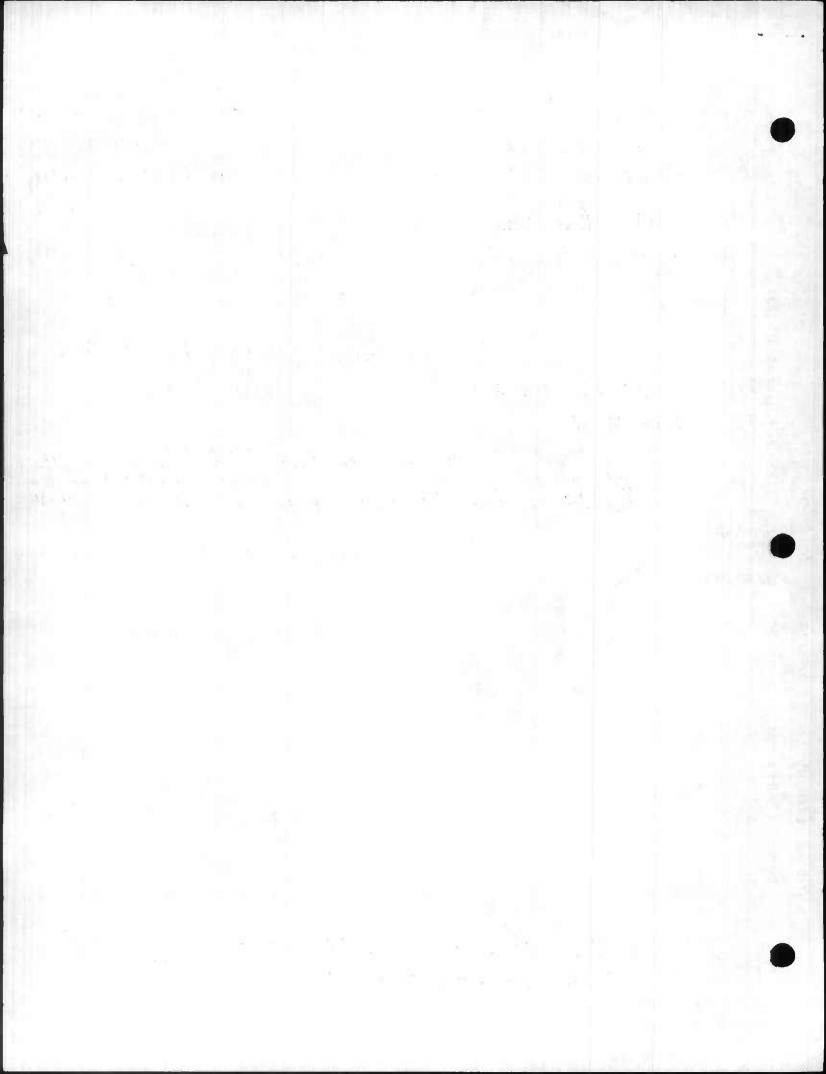
d cause of death (Itam 23a) (Typa, Print) 32. Registrer's Signeture

1, Bay, Year)

Sparks

DHMH 16 Rev 6/95

Registrar



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

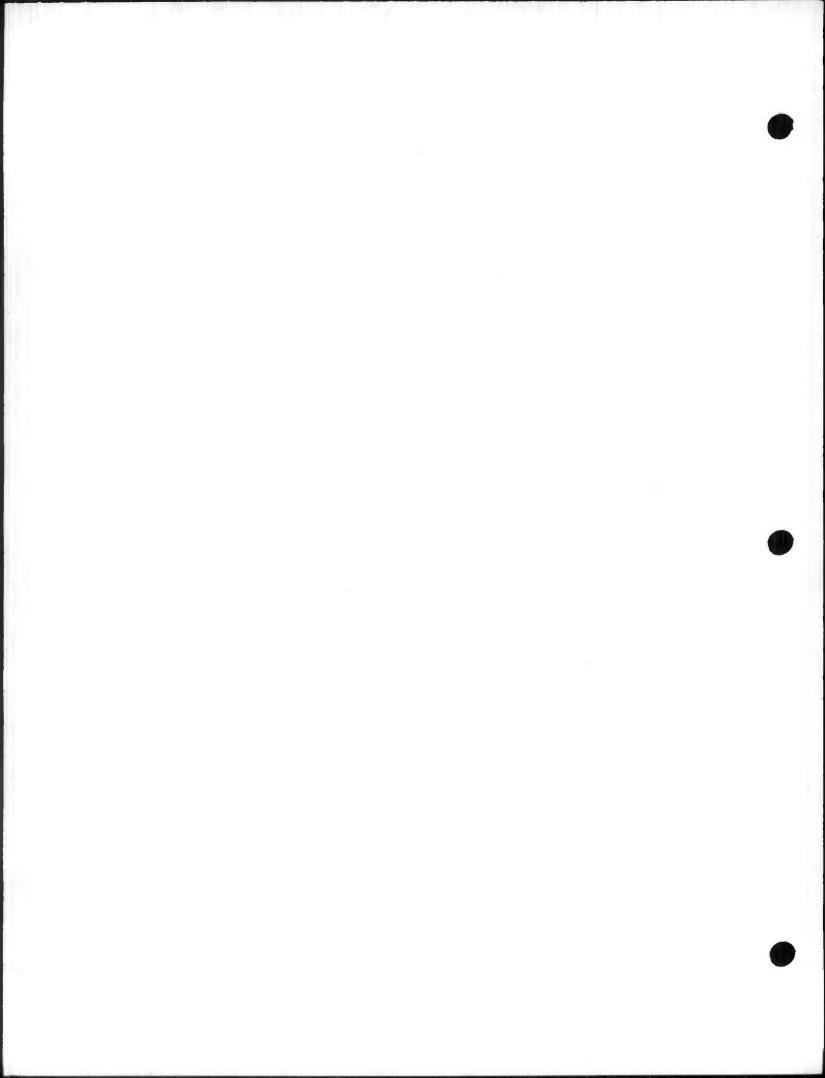
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	ENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.					
	DECEDENT'S NAME (First, Middle, Lest) LUCY	V. M	ARKS		2. DATE OF OEATH MONTH DAY	YEAR 7:15 A M				
5	030 00 000		(In yrs. last birthday)	UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN.	MAY 12, 1999 7. DATE OF BIRTH (Month, Day, Year) DEC. 19,1903	BIRTHPLACE (State or Foreign Country)				
oc.	9a. FACILITY NAME (If not Institution, give stre			CITY, TOWN OR LOCATION OF DE		VIRGINIA NTY OF DEATH				
CTO	ALICE MANOR NURSII	NG HOME		BALTIMORE		N/A				
L DIRECTOR		N/A	10c. CITY, 10	BALTTMORE		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 2095 ROCK ROSE A	AVENUE		101. ZIP CODE 21211		ZEN OF WHAT COUNTRY?				
BY FUN		12. WAS DECEOENT EVER IN FORCES? 1 YES	N U.S. ARMED 2 NO ATES X		IIC ORIGIN? (Specify Yes or No— n, Puerto Rican, etc.)	S. A. 14. RACE — American Indian, Black, Whita, etc. Specify: AFRO—AMERICAN				
COMPLETED	15. OECEDENT'S EDUCA (Specify only highest grade oc Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEOENT'S USU (Give kind of work life. Do NOT use re DOMES!	done during most of working fred.)	166. KIND OF BUSINESS/IND	DUSTRY				
OME	17. FATHER'S NAME (First, Middle, Last)	N/A	30120.		PRIVATE ME (First, Middle, Maiden Surname)	HOMES				
BE C	RICHARD FREEMAN			MARY	WHYCHE					
2	GEORGE H. MARKS	/ SON		RESS (Street and Number or Rural F	Route Number, City or Town, State, Zip					
	20a. METHOD OF DISPOSITION	and from State 20b.	PLACE ANODATE OF O	SPOSITION (Name of	DATE 20c. LOCATION -	1215 City or Town, State				
	4 Donation 6 Of Other (Specify) 177	ATT AR			115,1999BALTO.	MD.				
	(alumit	3. Louis	to me	CALVIN B. SCF	RUGGS FUNERAL H	OME				
	23. PART I. Enter the diseases, or con ahock, or heart fallure. Life	mplications that caused at only one cause on a	the death. Do not e	enter the mode of dying, such	as cardiac or respiratory arr	est, Approximate				
	IMMEDIATE CAUSE (Final									
TION	Sequentially list conditions, If any, leading to immediate disease or condition									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF):									
A	PART II. Other eignificant conditions	contributing to deeth be	ut not resulting in th	e underlying cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE				
PHYSICIAN: MEDIC	Somile	Clemente	<u> </u>		1 YES 2 JNO	OF DEATH?				
ICIA		HOSPITAL:	ОТ	28. PLACE OF DEATH (Che	ock only one)					
нү	1 YES 2 NO 1	28a. DATE OF INJURY	28b. TIME OF	fursing Home 5 - Residence	8 Other (Specify) 28d. DESCRIBE HOW INJURY OCC	CURED				
ΒY	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Year) 28s. PLACE OF INJURY building, etc. (Speci	— At home, farm, street	M 1 YES 2 NO	26I. LOCATION (Street and Number	or Rural Route Number,				
ETE	4 Homicide determined				City or Town, State)					
COMPLETED	29a. CERTIFIER 1 DERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowle On the bests of exemination	edge, death occurred at a and/or investigation, in	the time, data and place, and due my opinion, death occured at the	to the cause(s) and manner as state lime, data and place, and due to the	ed. cause(s) and manner as stated.				
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER	this_	- MO	29c. LICENSE NUM		SIGNED (Month, Day, Year)				
	30. NAME AND ADDRESS OF PERSON WHO C	1.2 NAIR	, 4419		RALTIMIRE MI	n 21211				
	MAY 1 4 1999	32. REGISTRAR'S SIGNA	ATURE G. A.	one of t						





Funeral

Director

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Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event and Data.

Physician

/Medical

Examiner

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After

page 2 s

the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

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The

Hospital or Attending Physician:

death.

after death Director:

24 hours a

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72 hours after

Baltimore, Maryland 21215-0020

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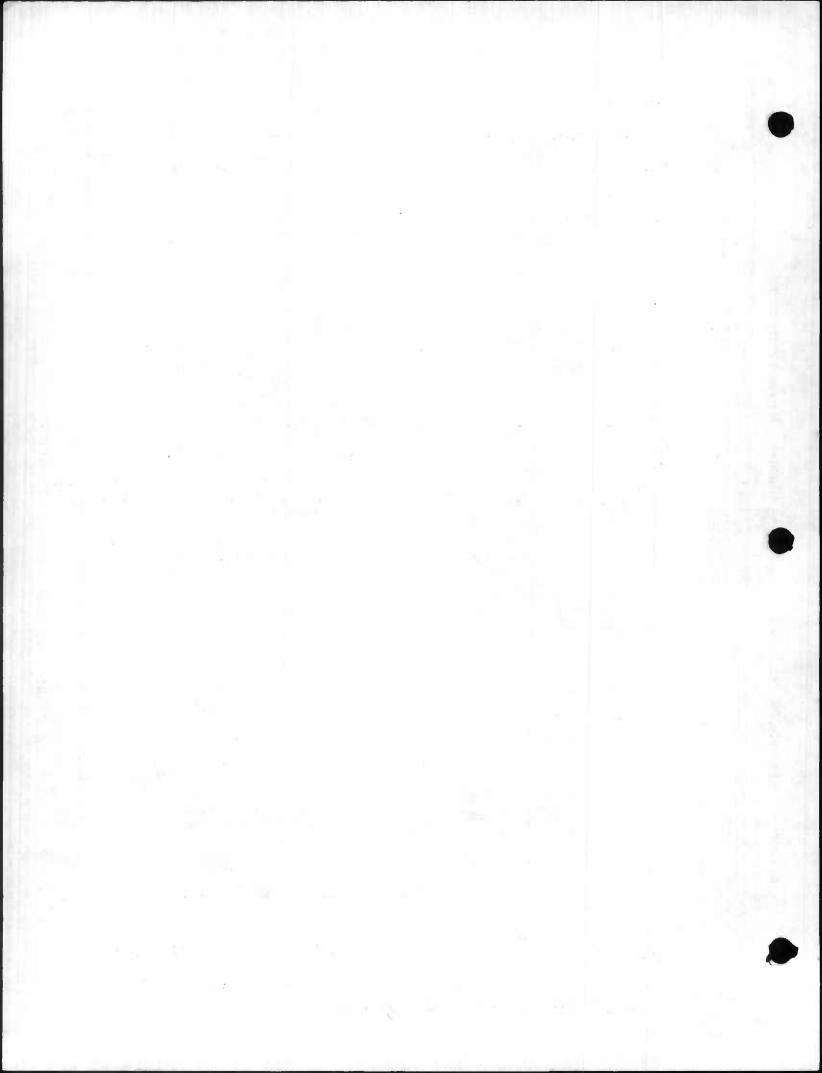
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ROBERT E. MEANS SR. 4, MAY 1999 1642 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 410 POPULAR GROVE STREET BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11-27-27 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Days Months Hours 17€M 2□ F 250-24-2387 71 Yrs. S.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 POPLAR GROVE 21223 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BRICK MASON CONSTRUCTION 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES POOLE LIZZIE SMITH 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ROBERT E. MEANS, JR. (SON) 4215 BELVIEU AVE. BALTIMORE. MD 21215 20e. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State WESTERN CEMETERY 5-14-99 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 uta 23a. Pert 1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on aach line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition rasulting in deeth) a Hypertensive Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Diabetes Mellitus þ Completed 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? INSPECTION 1 ☐ Yes 2 ☒ No 1 TYes 2 No Be 25. Was case rafarred to medical examinar? 26. Place of Daath (Check only one) Hospital: 1X Yes 2 No Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXVeturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicida 1 C-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifier Medicai (Check only one) 29b. Signeture and Jitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 5, 1999 MAY 30. Nema and addrass of person who completed during of death (Item 23a) (Type, Print) THEO DOLK M. Kin 111 Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Ray 6/95

32. Registuar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month McDevitt Year **Physician** Peter Sr. Joseph 11 1999 7:00p.m. May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 101 Osborne Avenue Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dale of Birth Month, Day, Year July 8, 1942 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 216-42-4798 15 M 2 F 56 Maryland Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, inside City Limits r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 101 Osborne Avenue 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Detes: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☐ No Specify. à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College, (1-4or 5+) Claims Adjuster Keystone Insurance permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if them 27 is marked
any injury or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Kunny (unk) Frank Fischer 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dana McDevitt (Wife) 101 Osborne Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 □ Other (Specify) New Cathedral Cemetery 5/14/99 Baltimore, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc 21. Signature of Funeral Service Licenses 1630 Edmondson Ave., Catonsville, Md. has mmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final five minutes disease or condition resulting in death) Examiner Examiner RU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lasl Bud Box 68760 01 Physician/Medical the Due to (or as a con of): ARDIOMUODATI P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 15 Yes 2□ No 3 Probably 4 Unknown SCULAR signed b Records, þ 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? 100 1 Yes 2 No 1 Yes 2 No Division of Vital a Hospital or Attending Physician: 24 hours after death. a Funeral Director: After this certifica letely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 □ Nursing Home 5 ■ Residence 6 □ Other (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homloide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

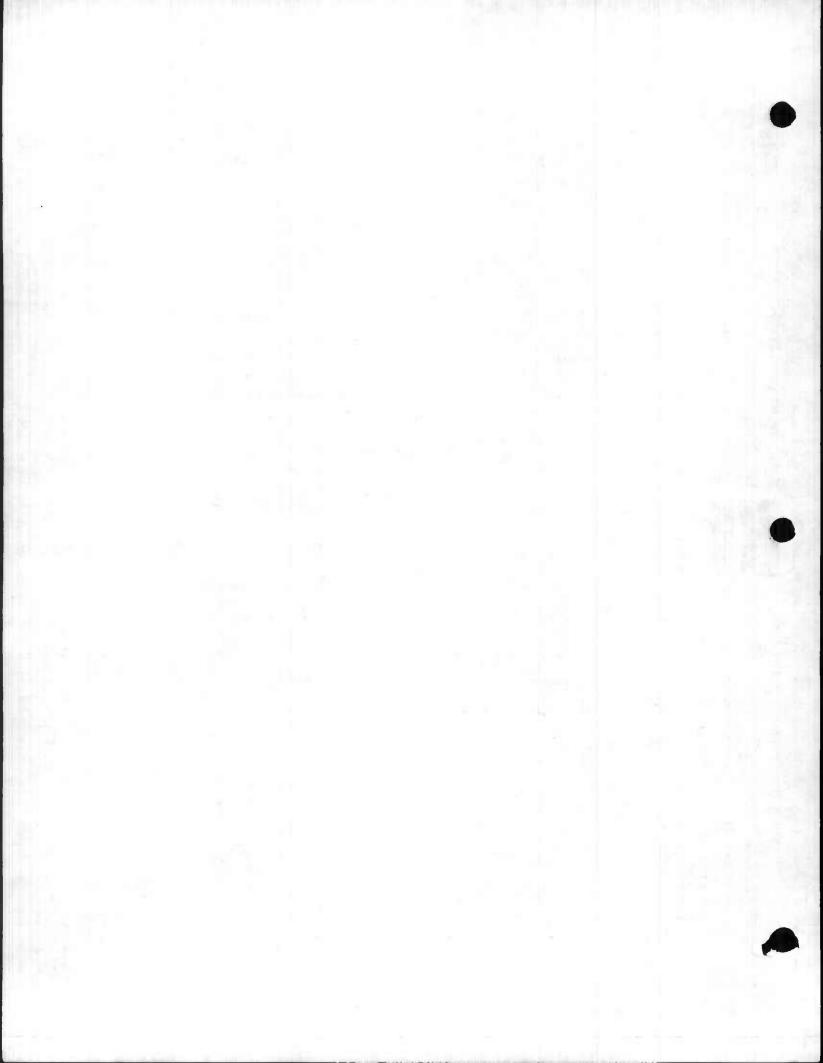
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING CARPIGLOGIST MARY LAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAFREN SLITE 300 BATTIMORE, MARYLAND 21229 3449 WILKENS AVENUE JONATHAN MD

State Registrar

31. Dete filed (Month, Day, Year)

MAY 1 4 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item#20b perFHg795 5/15/01 EW Certificate of Death AMENDED #7 PER FH G771 5/14/99AH Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Year Month **Physician** 05-11-99 10:52am ANDREW MCDUFFIE /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BAYVIEW MEDICAL CENTER BALTO. N/A If Under 1 Yeer 5. Sociel Security Number If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1**X** M 2□ F Yrs. 89 88 Director 248-01-9519 2-18-1909 GREATFALLS, SC Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow the Medical Examiner must be notified at BALTIMORE Yos 2 No Director MD n/a 288-4 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 5211 CEDGATE 21206 Funeral LN. U.S.A. flems : 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 'natural', or 1 Yes 2 No Specify: Specify: BLACK þ 3€ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 STEELWORKER BETHI, EHAM STEEL, Important: If Item 27 is marked other any injury or other tree 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental EVANS MCDUFFIE UNKNOWN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4500 ANNTANA AVE, BALTO, MD NAOMI WINDER (DAUGHTER) 21206 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crametory or other place) Dete 20c. Location - City or Town, Stete 1 GBurial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) DRUID RIDGE CEMETERY 18-99 OWINGSMILLS, Signature of Funerel Service Licensee 22. Name and Address of Facility LEROY O DYETT & SON FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** tmmediete Cause (Final diseese or condition resulting in deeth) /Medical - Chi deac arron Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760 level Physician/Medical Due to (or es e consequence of): momory Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 3 1 Yss 2 No 3 Probably 4 Unknown bengis d be det Records. 2 24b. Were autopsy findings aveilable prior to Completed 24a. Wes en autopsy completion of cause of death? page 2 1 ☐ Yes 1 ☐ Yes 2 No certificate Vital Attending Physician: director Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To Division of this funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred An Hospital or Atten-in 24 hours after death. The Director: After the further After 1 Netural 5 Pending 1 Yes 2 Accident investigation 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide in 24 hour. The Funeral Direction of tilled in Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) minan WD 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

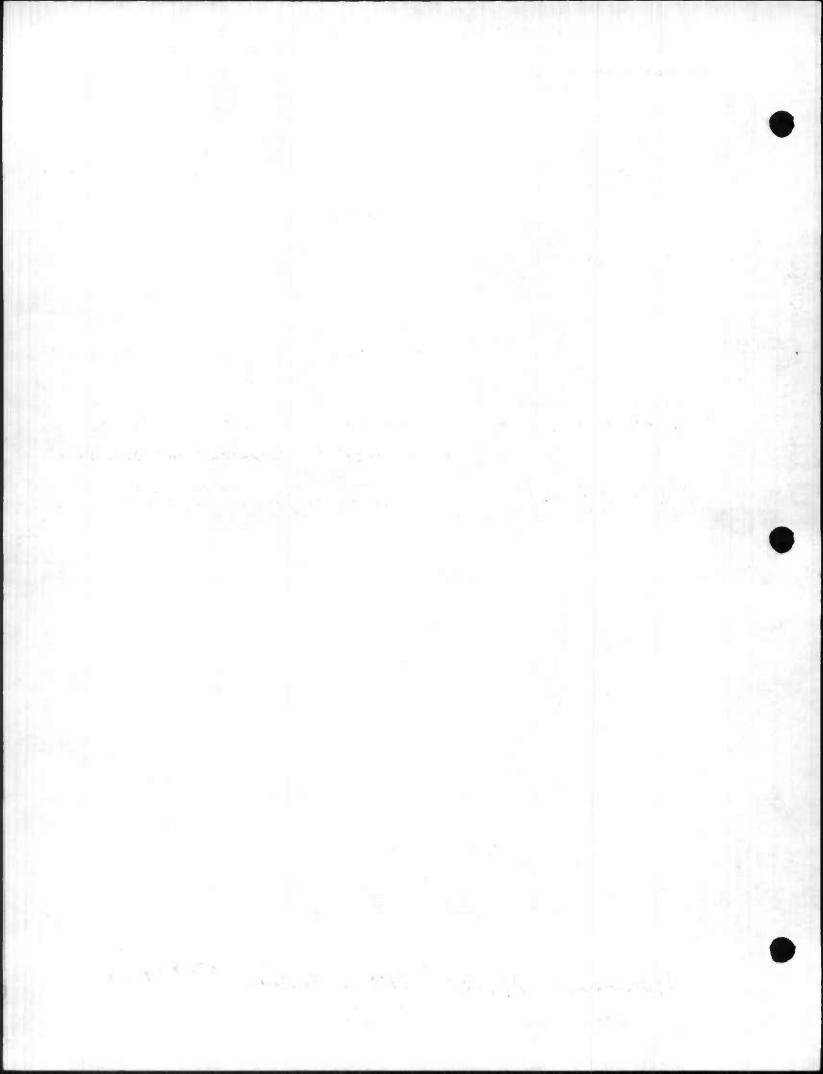
State Registrar MARGUEITE
31. Date filed (Month, Dey, Year)

MAY 1 4 1999

DHMH 16 Rev 6/95

ORIGINAL

Marko N 32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Death Month **Physician** Matthews 1999 Bettu May 02:10 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hopkins Bayview Medical Center Baltimore lonns N/A If Under 24 Hrs. 6. Sax If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec. 20,1923 Birthpiace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 28 F 75 Maryland 216-16-8310 Director Usuai Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinational by 1 ☐ Yes 2 No Director Colgate Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with United States 21224 7943 Eastdale Road Funerai death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural". or heary injury or other traumatic avantations. 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedanf Evar in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yas, Give Year or Dafas: 14. Race - Amarican Indian, 11. Marifai Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Housewife Own Home 10 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eva Rixse Andrew Sachs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen L. Carpenter/Daughter 7943 Eastdale Road Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5/15/1999 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Service Ligense 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsef and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical metastatic Colon cancer Examiner Due to (or as a consequenca of) Examiner certificate be executed physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Dua fo (or as a consequence of): 88 the attending 980 for 23b. Did tobacco use contribute to the cause of deeth? P.0. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. datached 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 8 24b. Were autopsy findings eveileble prior to 24a. Was an autopsy performed? Completed peen completion of causa of death? has 1 Yes 2500 1 🗌 Yes 2 X No certificata Attending Physician: funarai director, 25. Was cese referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) To 1 Yes 25 No 1 Mnpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima of 28c. Injury af Work? Certification: Aftar 1 Natural 5 Pending Investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide ò Hospital 24 hours edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the ceuse(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated. To the To the F 29c. Licanse number 29d. Dafa signed (Month, Day, Year) 29b. Signalure and little of certifier

P11339

4940 Eastern Avenue, Battimore, MD 21224

May 11, 1999

State Registrar van Eamond MD

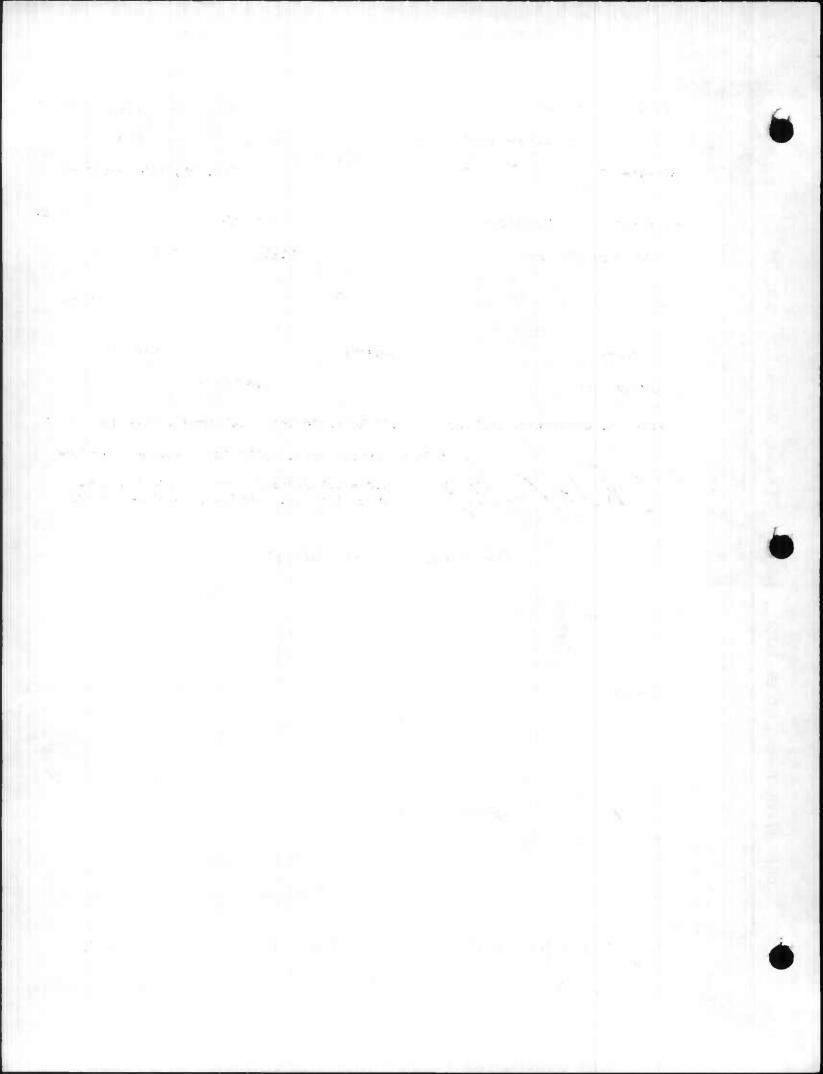
completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signature

30. Neme end eddress of person who

31. Dete filed (Manth, Pay, Yeer)

J. van Egmond MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 3. Time of Death 2. Dete of Death Month 1999 Patti Lou Musser May 12:15 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 706 Grand Valley Court Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. Sempor Dey 928 5. Sociel Security Number 9. Birthplece (State or Foreign Country) Pa 7. Age (In yrs. last birthday) 182-22-3394 10M 20F Yrs. Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Carroll Md. Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 Grand Valley Court 21157 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 1 Never Merried 2 Merried White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Roland Road Golf Elementery/Secondery (0-12) College (1-4or 5+) Office Manager Club 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Mae Gahagan Millard Franklin Griffith 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 706 Grand Valley Ct. Westminster, Md. 21157 Carl William Musser, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Greenmount Church Cem Hampstead, Md. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) May 22. Name and Address of Facility Eckhardt Funeral Chapel 21. Signature of Funerel Service License 3296 Charmil Dr. Manchester, Md.21102 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth LOPIAN TUBE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence ot) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work?

Examiner physician and s the burial-transit The law requires that the death certificate be executed P.O. Box 68760, signed by the atte Division of Vital Records. page 2 certificate or Attending Physician: director, this funeral Hospital or Attendin 24 hours after death.
 Funeral Director: Aft filled in by

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Funeral

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

27 is marked of traumatic evi-

Department of Health a Important if New 27 is any injury or other trau

Physician

/Medical Examiner

altimore, Maryland 21215-0020

Physician/Medical Completed by Be 25. Was case reterred to medical examiner? Medical Certification: To 1 Yes 2 No 27. Manner of Death 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier contriving Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

(Check only one)

Medical Examine: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and placa, end due to the cause(s) and menner steted.

29b. Signeture e

29d. Date signed (Month, Dey, Year)

30 Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) ASHINGTON HTS, Westminster, MD 21157 31. Date filed (Month, Dey, Year)

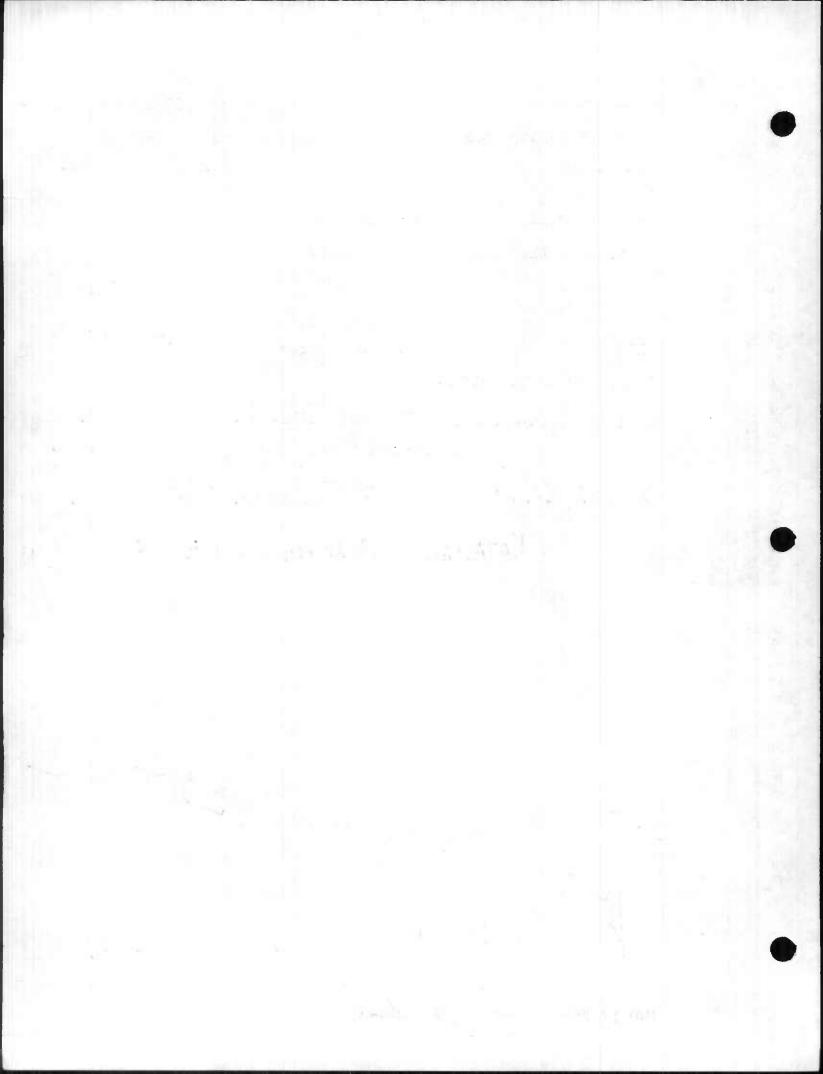
State Registrar

completely

within 2 To the ŝ

MAY 14 1999

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2 Dale of Death 3. Time of Deeth Month 1:20 AM 4b. City, Town, or Location of Deeth Name (If not institution, give street end new 4c. County of Death Tined a arce 19 If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) Birthpiace (State or Foreign Country) -10-4894 150M 20 F Months Days 10, 1910 Rhode Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1217 W. Fayette Street 21223 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Transportation Seaman 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Warren Miller Mary Boylan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Director State Anatomy Board, 655 W. Baltimore STreet 21201 Baltimore, MD art 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yee 2 No 3 Probably 24a Was an autonsy 24b. Were autopsy findings

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours aftar deeth with the Maryland Department of Health and Mental Hydlene. Important: If term 27 la marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic awart

Baltimore, Maryland 21215-0020

Physician

/Medicai

Examiner

10a. State

Directo

Funeral

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Funeral

Director

Examiner bunal-transi nding physician Physician/Medical signed by the af d be datached for þ Completed Be Medicai Certification: To this Director: After this d in by the funeral daeth.

or Attending Physician: The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

d	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cancer Skin Pace; Ho Korsakoff Psychosis	23
cancer some fact, in the same is some	_

	performed?	available prior to completion of cause of death?
	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
(Ch	eck only one)	

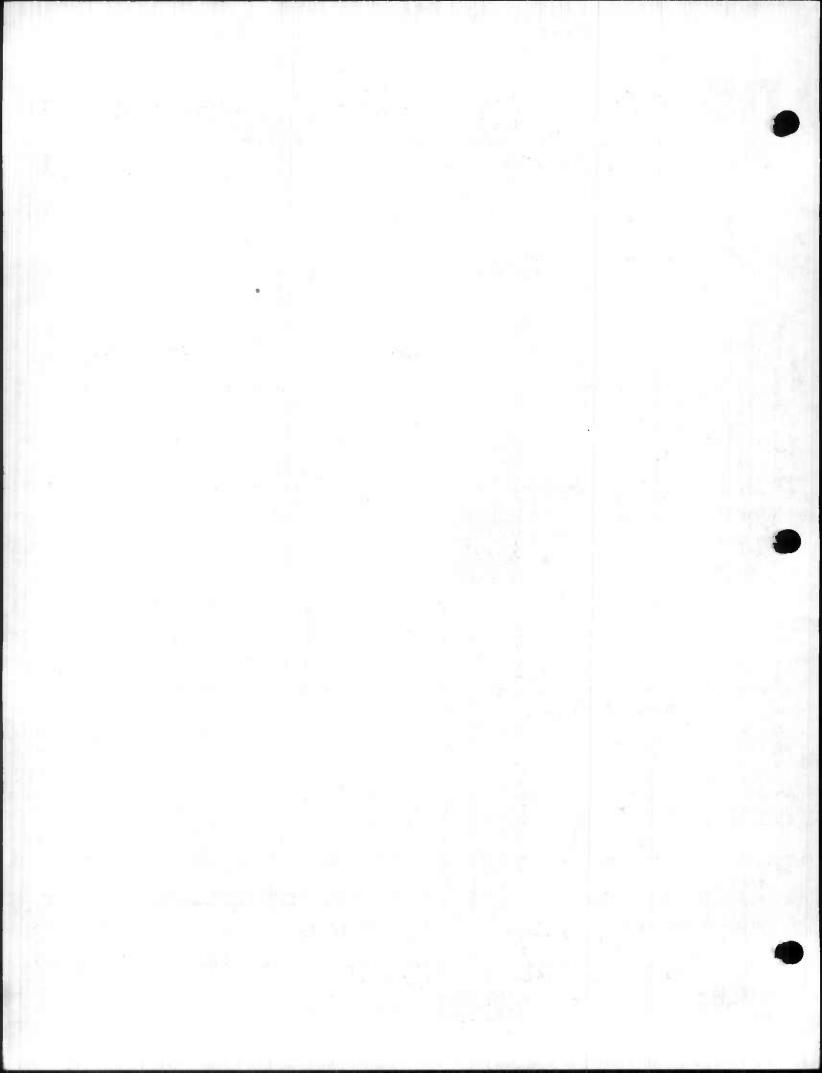
25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	af Death (Check only one) sing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 ☑ Natural 2 ☑ Accident	5 Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	286 M	o. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Sulcide 4 Homicide 6 Could not be determined		28e. Plece of Injury - Al h building, etc. (Speci	iome, farm, stree	28f. Location (Street and Number or Rural Route Num City or Town, State)		

29e. Certifier (Check only one)	1 Certifying Physic 2 Medical Examine	clan: To the best of my knowled r: On the basis of examination and manner stated.	dge, deeth occurred at the time, date end place, and and/or investigation, in my opinion, death occurred a	due to the cause(s) and menner as stated. at the time, dete end place, and due to the cause(s)
29h Signature an	d title of certifier		20c License number	20d Data claned (Month Day Voor)

m 23e) (Type, Print) MOUNT Royal Ave, Palto 2/2/7 ed cause of death (Item 23s) (Type, Print) 31. Date filed (Month, Day Year) MAY 1 4 1999

State Registrar 32. Registrar's Signature

within 24 hours of To the Funeral Di completely filled in the Hospital



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month 1999 00 9 April 3:30 AM 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street end number) 4c. County of Deeth POL Park 0+60 Millesville If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Data of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex 10 M 20 F Months Days Hours Yrs. 329141810 Illinois Usuel Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No AA M milleaville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? PUVK 1108 25 0 14. Raca - American Indian, Wes Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yas 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Bochelas a 12 _unknown Social Security Admin. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Arthur C. Marsh Volet King 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Pural Route Number, City or Town, State, Zip Code) Eunice Sampson/sister P.O. Box 477, Somonauk, Illinois 20b. Place of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4X Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licansee 22. Name end Address of Fecility ade, Director Wade, Ronald S State Anatomy Board, 655 W. Baltimore Street ran / u Baltimore, Maryland 21201 Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death Immediete Ceuse (Finel disease or condition resulting in death) 4 MOND ementia Due to (or es e consequence of): -icier Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disease or Injury 1510 thet initieted events resulting in deeth) Lest Due to (or es e consequence of): nutrition 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown alcono abuse 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner certificate be executed

68760

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Director

Funeral

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7 is marked other than "natural", or items 23s or 25s-f shot traumatic event, the Medical Examining must be notified at

2 should be filed within 72 is and Mental Hygiene. Is marked other than "nati

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum 2058.

Maryland 21215-0020

Examiner Physician/Medicai 2 Completed Be 10 Certification:

attending physician end ifor use es the buriel-transit certificate has this funeral After t death. of Attendi efter death Director: A filled in by

27. Menner of Deeth

1 Neturel

2 Accident

3 ☐ Sulcida

29a. Certifier

4 ☐ Homicide

(Check only one)

elone

5 Pending investigation

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signeture end title of cartifier

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and plece, and due to the causa(s) and menner steted.

29d. Dete signed (Month, Dey, Year)

30. Name end address of person who completed cause at yearth (Item 23a) (Type, Print)

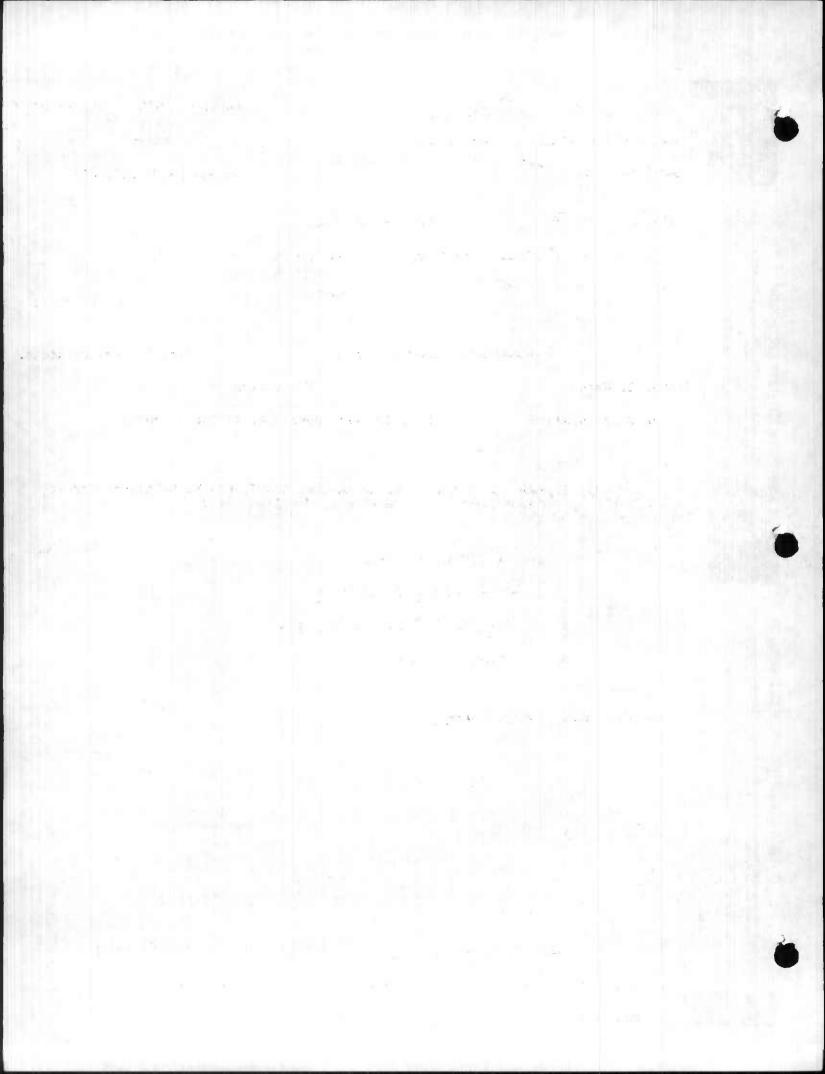
31. Dete filed (Month, Dey, Year) APR 2 6 1995 rapols 32/Registrer's Signeture

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Registrar

To the Hospital o within 24 hours of To the Funeral Di completely filled is

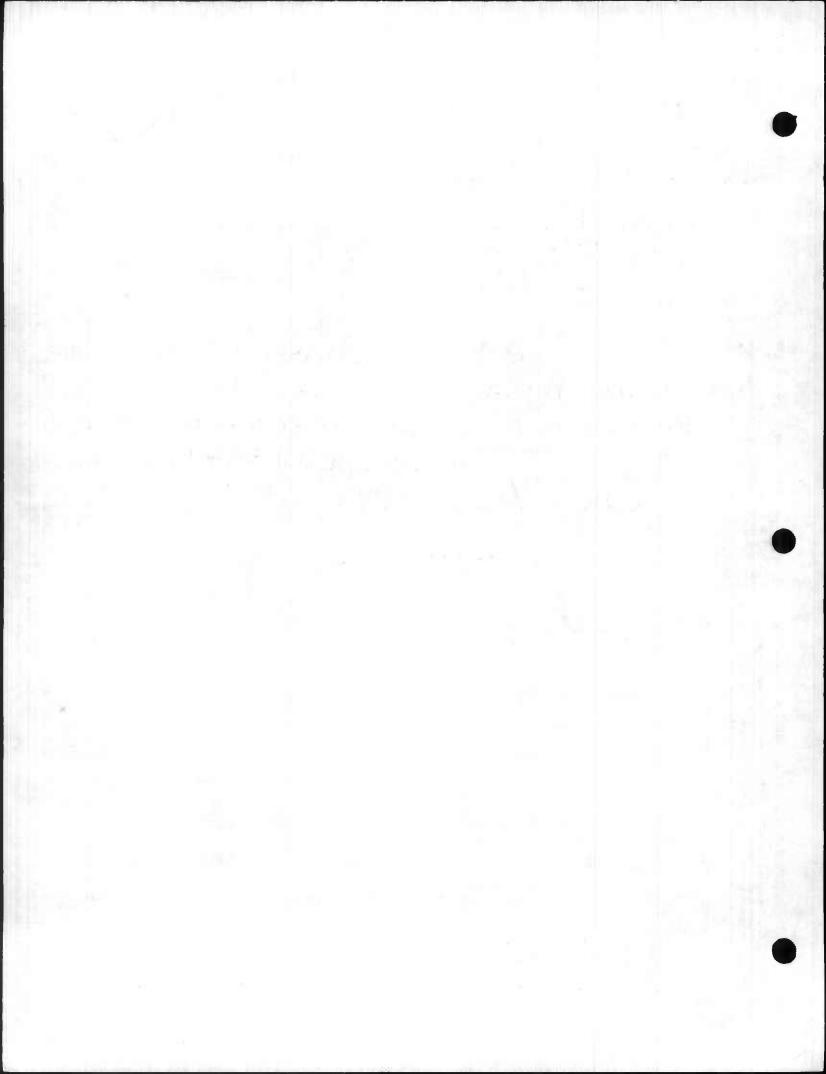
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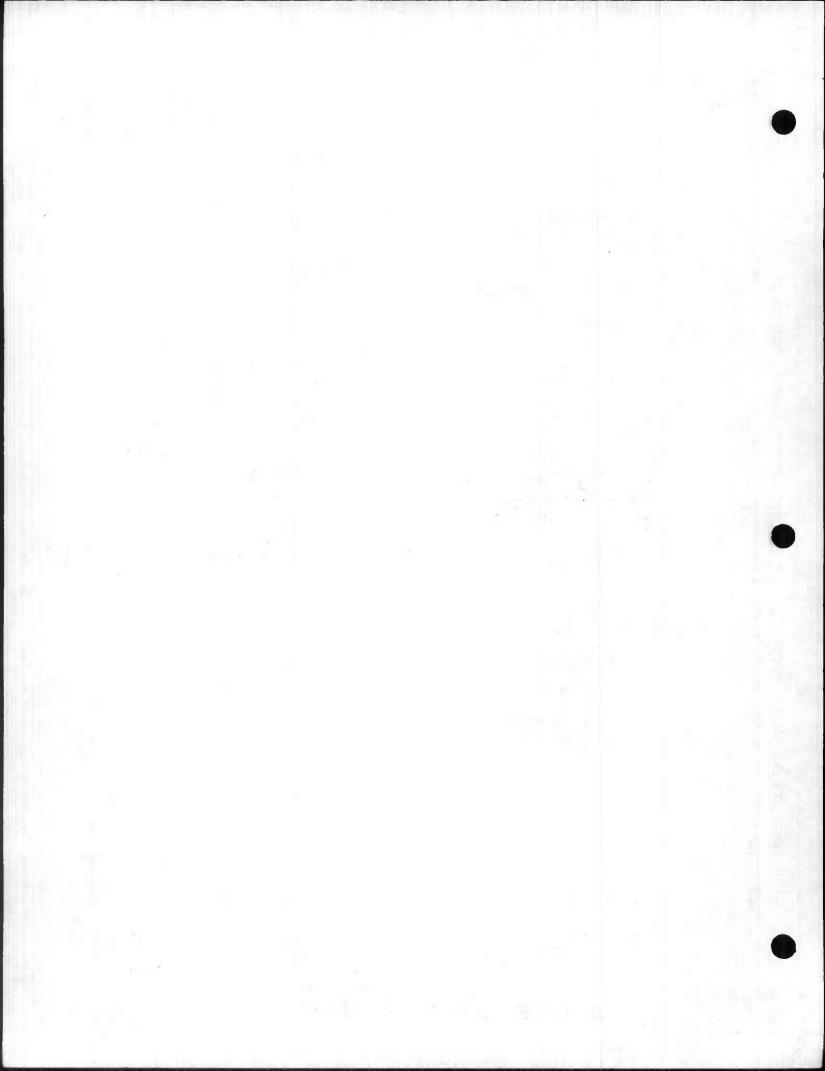
State of Maryland / Department of Health and Mental Hygiene

			Certifica	ate of D	<i>Death</i>		Reg. No.	9	5/24
	1. Decedent's Neme (First, Middle, Li	nst)				2. Date of De Month		Year	3. Time of Death
hysician /Medical	Bernice.	Otter				MAY	12. 1		1610 PM
Examiner	4a Facility Name (If not institution, gi	re street end number)		4b	. City, Town, or				TOTO IM
annici	LIBERTY MEDICAL	CENTED			BALTIMO	RE CITY		NIA	
		Sex 7. Age (In yrs.	last birthday) If Und	ser 1 Year	If Under 24 Hrs		rth	1 Birthola	ce (Stete or Forei
	210 21-5002	1 M 25XF	Yrs. Month	s Days	Hours Min.	-Month, D	LETO10	Samo	i A
	Usual Residence of Decedent	10				Dune	12,1100	Un	10
	10a. State 10b. County	10c. Cit	y, Town or Location					10d	I. Inside City Limit
Director	Mandant N/	4	Baltin	ACO					1 Yes 2□N
į	10e, Street and Number			10re			10- 00	MP - 1 C 1 -	2
ŝ	2000 61:6	Lan Aug	101.	Zip Code	11		10g. Citizen of	What Country	4
runera	2208 CIT	on The.		did	10		U	SI	T
	11. Marital Status	12. Wes Decedent Ever in U. Armed Forces?	S. 13. Wes Dec	pedent of His pecify Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or No to Rican, etc.)	5- 14. Rad Bla	ce - American ick, White, etc	
	1 Never Married 2 Merried	1 ☐ Yes 2 No		21XNo	Specify:		Specif	1	
j	3 Widowed 4 □ Divorced	Year or Detes:		-44.0	op cony.		Opecin	ive	aro
	15. Decedent's E (Specify only highest gr	ducation	16a. Decedent's U:	suel Occupat	tion uring most of wo	drina	16b. Kind of B	usiness/Indu	stuly
	Elementary/Secondary (0-12)	Coljege (1-4or 5+)	life. DO NOT	use retired)	1	g	Λ.	11	/
			Hom	em	aker		OWY	2 11	ome
	17 Father's Name (First, Middle, Last	211			18. Mother's Nar	me (First, Middle	, Maiden Sumen	ne)	
-	Phelix V	Vallace			INCP	phir	18	A/1	en
	19a. Informant's Neme/Relationship	Type, Print)	19b. Meiling Addre	ss (Street a	nd Number or Ru	Iral Route Numb	per, City or Town.	State, Zip C	ode)
	Mrs Blanch	o Pottiford	21041	Mait	tier	AND	Ralta	M	71716
	20a. Method of Disposition	20b. P	lace of Disposition (A	lame of	1161	Date.	20c. Location	- City or Town	State
	1 X Burial 2 Cremetion 3	Removel from Stete	emetery, cremetory p	r other place).	5/19/00	1	1	1 1 1
	4 Donation 5 Other (Special		iryland	Nat	ional	-11179	Laur	e , 1	Ma.
	21. Signature of Funeral Service Lice	799 (1)		and Address	of Facility	E.	neral	Llow	0
	Monk, d	KUM	2777	PILL	North	Aug	12 CIT	Ma	21716
	23a. Part I Enter the disease, or com shock, or heart hilure. List only	plications thet ceused the death	n. Do not enter the m	ode of dying	, such es cardia	or respiretory	errest,	J TITOL	pproximete
	STOP OF HAME WHOLE THE CLIST ONLY	one cause on eech line.						C	ntervel Between Inset and Death
	Immediete Cause (Finel								
	disease or condition resulting in death)	a Arterioscler			ular Dis	sease		1	
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Examiner		b							
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edical	resulting in death) Last	Due to (or	r as e consequence o	n):					
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Physician/								1	
18	Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlying	cause give	n in Pert f.	23b. Dld	tobacco use co	ontribute to ti	he cause of dea
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2						24e. We	an autopsy	24b. Were	autopsy finding
Completed by						perl	omed?	comp of de	able prior to pletion of cause
티							ECTION		
						10	Yes 2 No	101	Yes 2□ No
3	25. Was case referred to medical examiner?	11			26. Place of De	eth (Check only	one)		
2	XXXXVes 2□ No		ER/Outpatient 3		4 LI Nursing F	lome 5□ Res	idence 6 Oth	ner (Specify)	
ü	27. Manner of Death 1XNaturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury occur	bern	
1	2 Accident investigatio		М		es 2 No				
	3 Suicide 6 Could not b		me, ferm, street, fact	ory, office		28f. Location	Street and Numi	ber or Rural F	Route Number,
Certification:	- CITOMOO	bullottig, etc. (Specif)	"			Only or 70	wii, Siele/		
-	29a. Certifier 1☐ Certifying Pt	ysician: To the best of my know	wledge, death occurre	d et the time	a, date and place	end due to the	cause(s) end me	enner es stat	ed.
edical	(Check only one) Medical Exar	niner: On the basis of examiner and menner stated.	ion end/or investigation	on, in my opi	nion, deeth occu	irred at the time	date and piece,	and due to th	ne cause(s)
ŝ	29b. Signature and title of certifier		12	9c. License	number		29d. Date signe	ed (Month. Dr	v Year)
		11 1							
	y Televan	w,101.D.		OCME	2		MAY	13, 19	777
	30. Name and address of person who	completed cause of death (Item							
	Duseph f	estance 111	Penn Stre	et, Ba	altimore	, Marvl	and 2120)1	
ite	31. Date filed (Month, Day, Year)	32. Registrer's Signe	17 17 17 17			-			
trar	MAY 1 4 1990	Deneva	19 10	21/1	,				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland /	Certificate of	Death	Reg	. No.	15725					
Physician	1. Decedent's Name (First, Middle, Last Sally Ann	Papas			2. Dete of Death May 12,	T999 Year	3. Time of Death 7:05 AM					
/Medical Examiner	4a Facility Name (If not institution, give			4b. City, Town, or Loc		4c. County of Deat						
Ladiffiler	7810 Charlesmount	Road		Dundalk		Baltimor	e					
Funeral Director	5. Social Security Number 6. Se 215-34-1143	7. Age (In yrs. last	birthday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) June 12	(ear) 9. Birt	hpleca (State or Foreign unity) ennsylvani					
taryland show solet	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits					
the Maryland 28a-f show notified at	Maryland Baltimor	e D	undalk				1 ☐ Yes 2 No					
th with the Ma 23s or 28s-f1 wat be notified	10e. Street and Number 7810 Charlesmount	Road	10f. Zip Code 212:	22	100	Citizen of What Co USA	untry?					
21215-0020 d within 72 hours after death with the Manyla glene. In than "natural", or thems 23s or 28s-f shot the Medical Exeminer, must be notified as completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes. 2 No It Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No		city Yes or No- tican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.					
21215-0 ed within 72 ho ser than "naturn 4, the Medical.	15. Decedent's Edu (Specify only highest grad	ication 16 completed)	Sa. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working	16	b. Kind of Business/	Industry					
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	17. Father's Name (First, Middle, Last)	iden Sumeme)	-									
should be rid Mental marked c	Stewart E. Russ	sell		Adeline	Carper	ter						
Aar 2 sh and la m	19a. Informant's Neme/Relationship (T)		9b. Mailing Address (Street									
C = 00 F	Peter P. Papas 20a. Method of Disposition	Peter P. Papas (husband) 7810 Charlesmount Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20b. Place of Disposition (Name of cemetery, cremetory or other place)										
Page ment of ant: If ury or	1€Burlal 2 □ Cremelion 3 □F □ Donation 5 □ Other (Specify)	Oak	Lawn Cemet	ery 5	/15/99	Baltimo						
Demit Depart Import any in and any in and any in and any in and any in and and and and and and and and and an	21. Signature of Fune Reservice Licens	2-1	1407 old	ki füheral Eastern Av	enue Es	sex, Mary	land 21221					
Physician	23a Part Enter the disease, or comp andsk or heart failure. List only o	ications that caused the deeth. D he cause on each line.	o not enter tha mode of dyi	ng, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Deeth					
/Medical Examiner	immediata Causa (Final diseases or condition and the tastatic Breast Concer 3 years											
	resulting in death)		a consequence of):				9					
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66 / 60, fileste be executed physician and as the bunal-transit edical Examiner	Cause (Disease or Injury c. Due to (or as a consequence of):											
The state of the s	d.											
Beath cert attendin of for use	Part It. Other algnificant conditions con	noo use contribute	se contribute to the cause of death?									
A.C. BOX hat the death certified by the attending letached for use a letached for use a PhysiciaryM	Partit. Other arginicant conditions con	23b. Did tobacco use contribute to the cause of death 1 Yea 2 No 3 Probably 4 Unknow										
es the signed be de												
Ital necords, P.O. box to slan. The law requires that the death certificate has been signed by the attending ctor, page 2 should be detached for use as Be Completed by Physiclan/Mc					24a. Was an performe	ed?	Were autopsy findings available prior to completion of cause of death?					
VICAL ME iclan: The lav certificate has rector, page 2 Be Comp					1 ☐ Yas	2 No	1 ☐ Yes 2 ☐ No					
Clan: clan: sector, Be		Hospitel:	0:	26. Place of Death								
Physician: ribis certific ral director,	1 Yes 20 No	1 L Inpatient 2 L ER/	Outpatient 3LI DOA		ne 5 XResiden 8d. Describe how	ce 8 Other (Spe	city)					
After After	1 Natural 5 Pending investigation	(Month, Day Year)	Injury Wo	rk?]Yes 2□No		,						
Invision of vital necords, P.O. for Attending Physician: The law requires that the date death. Director: After this certificate has been signed by the bineral director, page 2 should be detached in by the funeral director, page 2 should be detached entitioation: To Be Completed by Physis	3 Sulcide 6 Could not be detarmined	28e. Placa of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Street end Number or Rural Route Number, City or Town, Stata)							
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		sician: To the best of my knowled ner: On the basis of examination and mannar stated.										
within To the compl	29b. Signature and title of certifier		29c. Licen			d. Date signed (Mont						
		J. m	-0)45390		5/12/	19					
	30. Name and addrass of person who co	ompleted causa of death (Item 23)	(Type, Print) 6830	Hospital D	rive Su	ite 206						
044	31. Date filed (Month, Dey, Year)	32. Registrar's Signature	Rossy	Hospital L ille Maryl	and 2123	37						
State Registrar	MAY 14	1999 Deneva	D. Spo	uls								



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Werner Puchta 1999 11 7:00 A.M. May 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 805 Coxswain Way #307 Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 78 Yrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 217 34 8476 1 M 2□ F Nov. 9, 1920 Germany Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes \$ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 805 Coxswain Way #307 United States 11 Marital Status Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 21 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Grown Cork and Elementary/Secondary (0-12) College (1-4or 5+) Sea1

Tool and Die Maker

20b. Plece of Disposition (Name of

18. Mother's Name (First, Middle, Maiden Surname)

HANJUER STREET, BATT MORE MAPLANT

Bertha Schnellert

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

805 Coxswain Way #308 Annapolis Maryland 21401

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

17. Father's Name (First, Middle, Last)

Gerda I. Puchta

19a. Informant's Name/Reletionship (Type, Print)

Wife

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aD

DEINDITZ

Otto Puchta

Directo

Funeral

À

Completed

Be

To

Funeral

Director

natural, or flams 23a or 25a-f show

Pages 1 and 2 should be filed within 72 hours after

Health and Mental tant: If Hem 27 is marked

Saitimore, Maryland 21215-0020

The law requires that the death certificate be execu physician s the burial 3 signed b To the Hospital or Attanding Physician: s after deau... Vithin 24 hours after Company to the Funeral Director:

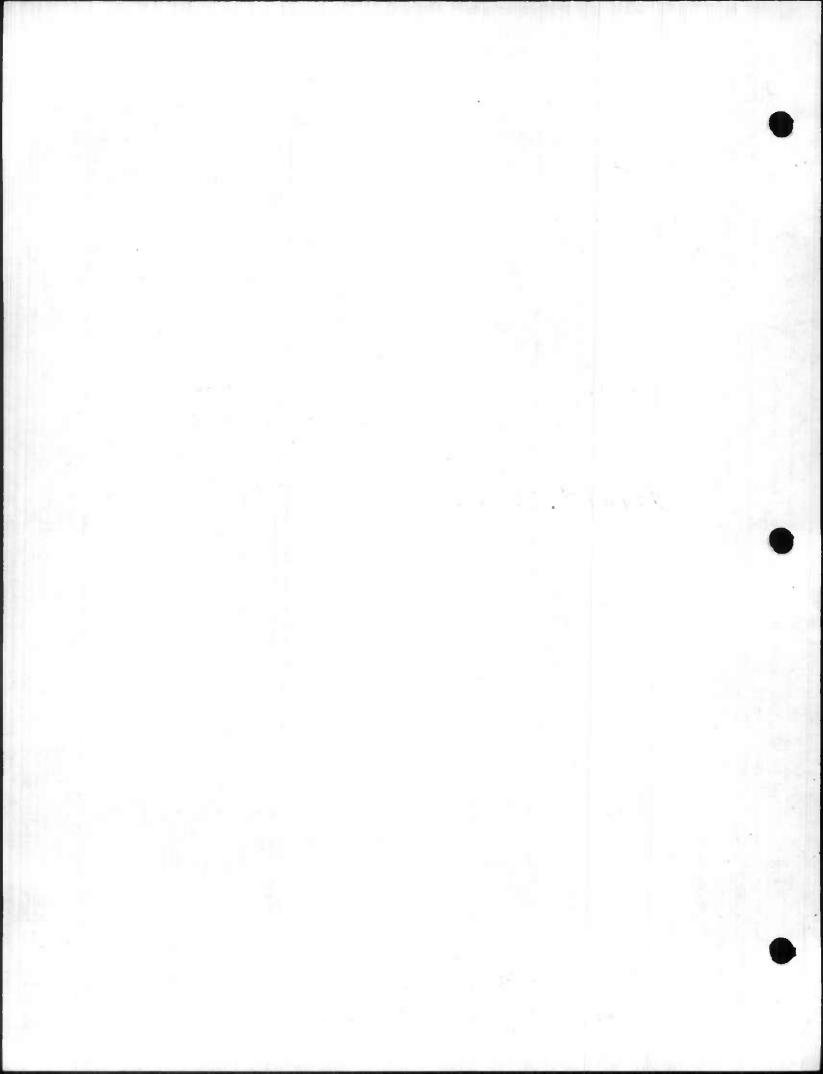
Division of Vital Records, P.O. Box 68760,

20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ Removal fro	20b. Plece of Disposition (Name of cemetery, crematory or other place	a) May 12, 1999	20c. Location - (City or Town, State
4 □ Donetion 5 □ Other (Specify)	Metropolitan Cres	natory	Alexand	lria Virginia
21. Signeture of Funeral Service Licensee Muchaul & Blo		ss of Facility Evans Funeral lapolis Rd. Bowid		
23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one common of the				Approximate Interval Between Onset and Death
Part ff. Other significant conditions contributing to	death but not resulting in the underlying cause giv		/	tributs to the causs of death
		24a. We peri	s an autopsy formed?	24b. Were autopsy findings available prior to completion of cause of death?
		1 🗆	Yas 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of Deeth (Check only	one)	
Hospital:	Inpatient 2 ER/Outpatient 3 DOA Oth	er: 4 Nursing Home 5 PRes	idence 6 Othe	or (Specify)
2 Accident Investigation	te of Injury onth, Day Year) 28b. Time of linjury M 28c. Injury Worl 1	yat 28d. Describe ∢? Yes 2 □ No	how injury occurre	ed
3 Suicide 6 Could not be determined 28e. Pla	ca of Injury - At home, farm, street, factory, office Iding, etc. (Specify)	281. Location City or To	(Street and Number own, Stete)	er or Rural Route Number,
(Check only 2 Medical Examiner: On the	he best of my knowledge, deeth occurred at the tim basis of examination and/or Investigation, in my or anner stated.	ne, date and placa, and due to the pinion, death occurred at the time	cause(s) and mar , date and placa, a	nner as stated. Indidue to the cause(s)
	29c. License			

State Registrar

OCEN

31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#31 perDVR G771 5/14/99 EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 **Physician** 6:00AM Robert W. Perkins 12 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore University of Maryland Med. Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Country) New York 6. Sex **Funeral** Days 1XM 2 F Hours 243226670 Months **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-1 show traumetic event, the Medical Examiner must be notified at Talbot MD Easton 1 ☐ Yes 2 No Directo 10e, Street and Number 10f. Zlp Code 10g. Citizen of What Country? Goldsborough 640 21601 USA Funeral 12, Wes Decedent Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No WW II If Yes, Give 14. Race - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specity: White by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Writer Novelist 18. Mother's Name (First, Middle, Melden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Heart: If item 27 is marked oth lary or other traumatic even Be Grafton Perkins Helen Edmunds 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1914 Sulgrave Ave. #2 Baltimore, MD21209 Morgan B. Perkins/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 05/13/99 Department of Important: If any injury or Baltimore, MD Metro Crematory, Inc. 21. Signature of Funeral Service Licenspe ²² Neme and Address of Facility Cremation Society of Maryland, Inc. un Regorchik 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Interstitial pulmonary fibrosis Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner Cytomegalovirus Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown disease þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes an eutopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpetient 3 DOA Certification: To 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be asscuted attending physician and for use as the burial-transit Records, P.O. Box 68760, been signed by the should be detached After this certificate ha funeral director, page Division of Vital al or Attending Physician: The safter death.

I Director: After this certificated in by the funeral director, pa To the Hospital or within 24 hours aft To the Funeral Dis completaly filled in

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

State Registrar

edicai

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Un MD PEY2

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
Heui Yoo M.D. University of Mary)

32. Registrar's Signature

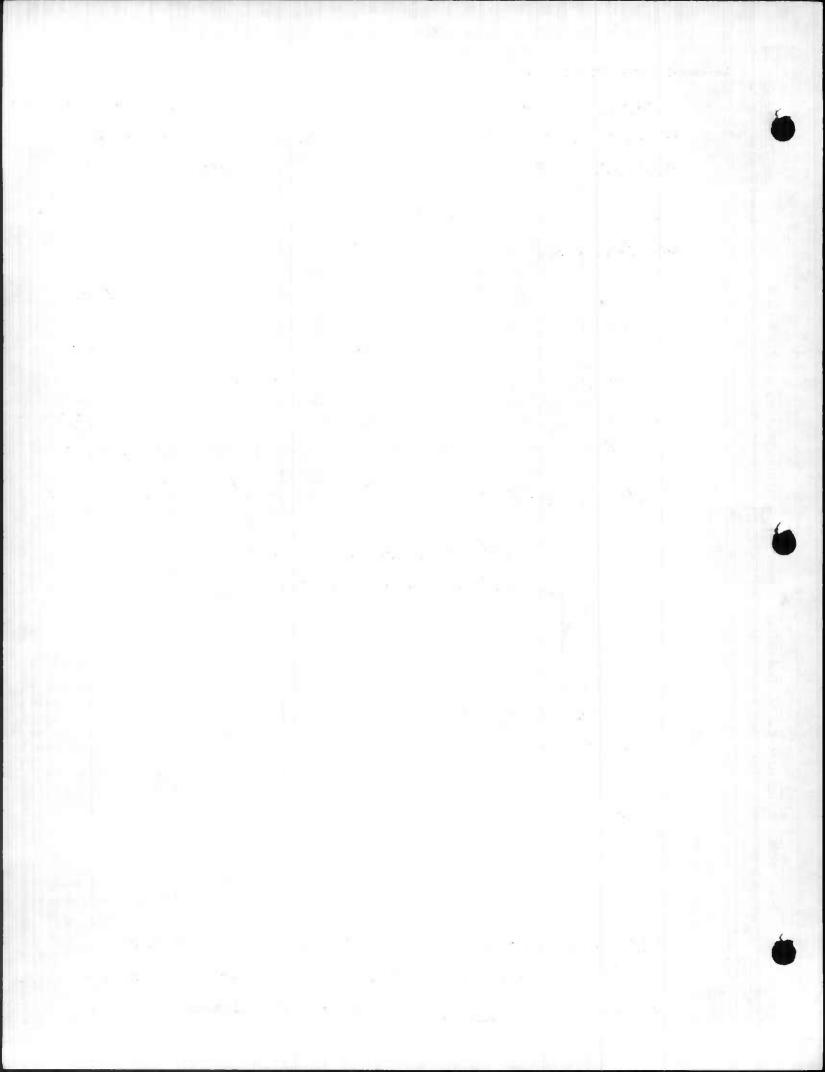
Maryland 22 5. Orene St, Baltimore, MD.

29d. Dete signed (Month, Dey, Year)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** May 12, 1999 6:45 p.m. George н. Petri /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Parkville Baltimore 8113 Dalesford Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 25, 1910

Birthplace (Steta or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1₽M 2□F Yrs. 213-07-7928 Director 88 Usuat Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Parkville 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Norma 23a 8113 Dalesford Road 21234 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Merried b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3∑ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Bethlehem Steel Supervisor 18. Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middla, Last) Be permit. Pages 1 and 2 should be l Department of Health and Mental Important: if them 27 is marked of any injury or other traumatic eve Wendell A. Petri Mary Smith 2 19a. Informant's Name/Retationship (Type, Pnint) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7448 Forrest Ave. Baltimore, Maryland 21234 Donald C. Petri / Son 20a. Method of Disposition 20b Place of Disposition (Nama of 20c. Location - City or Town, Stata Dete cemetery, cremetory or other piece) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Sensity) 5/15/99 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Puneral Sa vice Licensee 22. Nama and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 an 23a. Part1. Enter the disease, or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause a small line. Approximate Interval Between Onset and Death **Physician** /Medical FAILUREtmmediate Cause (Finel RESPIRATORY disease or condition resulting In death) **Examiner** Due to (or as a consequence of): Examiner BLONCHIOGENIC CALCIN OMA the death certificate be executed Sequentially list conditions, if any, teading to immediate ceusa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of): C16 HROTTE ABUST 950 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 → Yes 2 No 3 Probably 4 Unknown signed b Records. þ The law requires 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medicat axaminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2₽No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Netural 5 Panding NA 1 Yes 2 No Invastigation death 2 Accident 24 hours after deat Funeral Director: 6 Coutd not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routs Number, City or Town, State) 3 ☐ Suicide 4 Homicide filled in Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only within 2 To the F one) 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) D25010 2/13/99

State Registrar

Serena

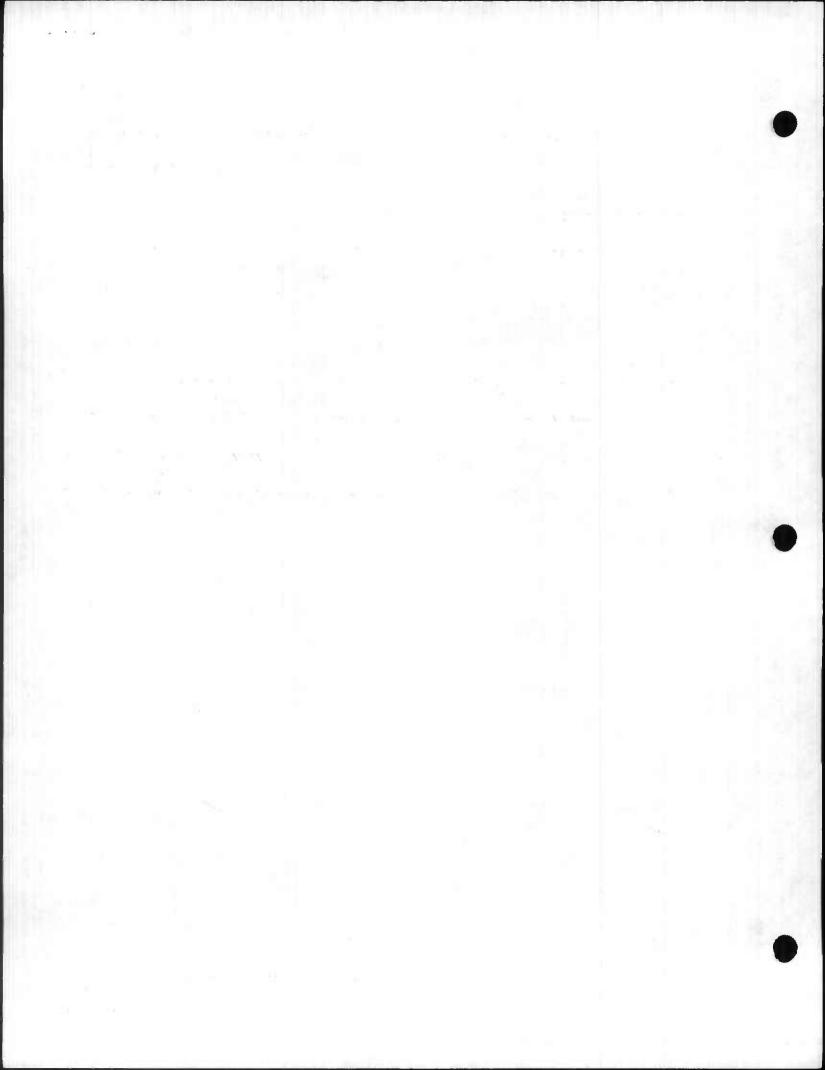
8035 a Harford Road M.D. 32. Registrar's Signetur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nolan,

routs

Parkville, Maryland



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth [™]1999 May 12, Mary G. Pindell 6:33 p.m. 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Newport Assisted Living Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Nov. 24, 1909 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 □ M 2 🔀 F 89 Yrs. 219-34-0897 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. 1 Yes 2 No Baltimore Reisterstown 10f. Zip Code 10g. Cifizen of Whet Country? 10e. Street and Number 505 Bond Ave. 21136 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Rece - Amarican Indian, Bleck, White, atc. 11. Merital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Eiamentary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Housewife 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fethar's Neme (First, Middle, Last) William John Georgius Josephine Anne Schilpp 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Gretchen Hoover - Daughter 505 Bond Ave., Reisterstown, Md. 21136 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State Lorraine Park Cemetery May 15, 1999 Woodlawn, Md. 4 Donation 5 Other (Specify) 22. Name end Address of Facility Eckhardt Funeral Chapel 21. Signeture of Funaral Sarvice Licenses 11605 Reisterstown Rd., Owings Mills, Md. 21117 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, failure. List only one cause on each line. Approximate Interval Between Onsel and Deeth 23a. Pert1. Enter the PHLMOUARY Immediate Cause (Finai CHRONIC OBSTRUCTIVE 50 YE 4R disaase or condition rasulting in death) Due to (or es e consequence of). Sequantially list conditions, if eny, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in daeth) Lest Due to (or es a consequence of): Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Onknown PARKINSON'S DISTASE OSTE O HETHRINS 24b. Were eutopsy findings availabla prior to completion of ceuse of death? 24e. Wes an autopsy performed? 1 Yes 2 BANG 1 Yes 20 No 26. Piece of Deeth (Check only onle) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

ettending physicien end for use as the buriel-transit requires that the death certificate be executed P.O. Box 68760. the signed by the Records, should b law. certificate has blirector, page 2 s The Division of Vital director. or Attanding Physician: this After this death. ofter death
Director: A To the Hospital or within 24 hours eff To the Funerel Di completely filled in

Physician

/Medical

Examiner

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Funeral

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Certification: To

Medical

Funeral

Director

i Hygiene. other than "natural", or items 23a or 28a-f show 'ent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner man and once.

Physician /Medical

Examiner

with the Maryland

25. Wes cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accidant 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 - Homicida

1 Cortifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. Licensa number

math 050164 5/13/9-

30. Neme end address of person who completed couse of deeth (Item 23a) (Typ), Print)

MAIN Street - 5-200 - KEISENSTOWN, MD 21136

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

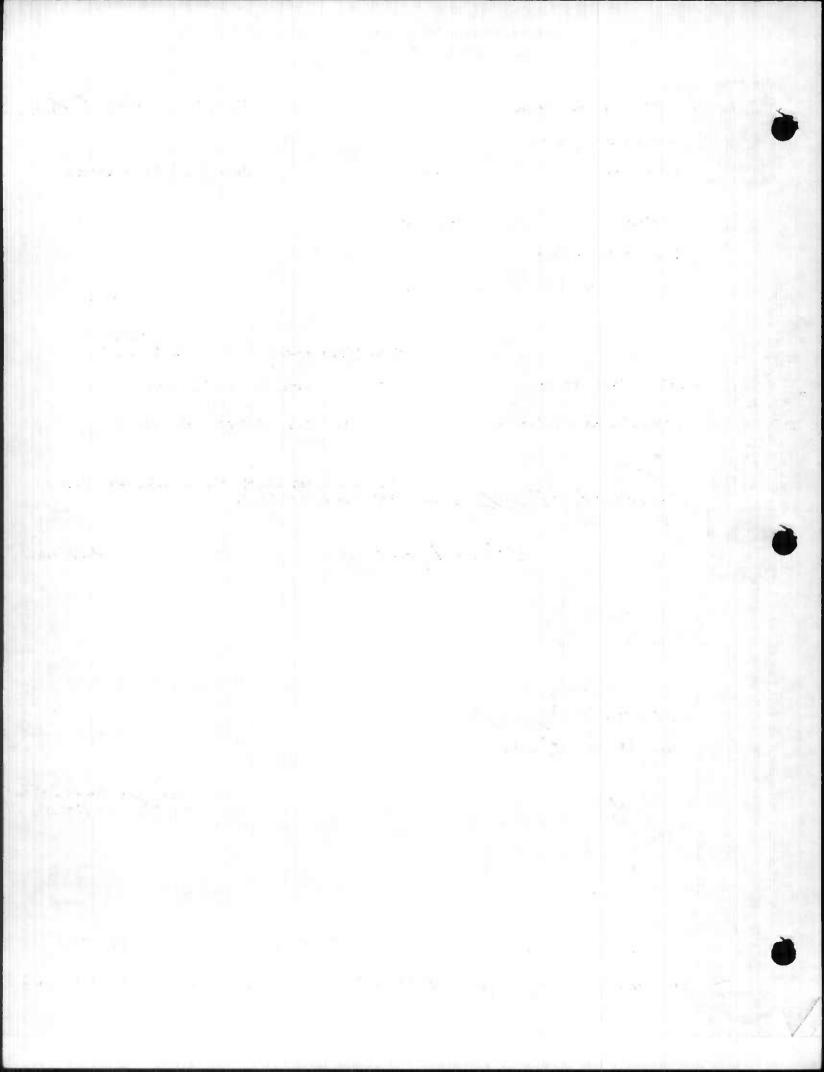
32. Ragistrer's Signeture

representation of the contract

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 | 5730

			Certificate	e of E	Death		Reg. No.			
21	1. Decedent's Name (First, Middle, Las	ot)				2. Dete of Dec	eth Dey	Veer	3. Time of Death	
Physician /Medical	Michael A. P	ayne				APRIL	28 1	799	5 2PM	
Examiner	4a Facility Neme (If not institution, give	street end number)		4t	o. City, Town, or	Location of Deeth	4c. County	of Death		
	Mercy Stella Mar				Baltim					
Funeral Director	5. Social Security Number 6. Si 217–60–2863	7. Age (In yrs. las	Months	1 Year Days	Hours Min		y. Year) , 1953	9. Birthple Count Mary	ece (Stete or Foreig try) 'land	חון
pue *	10e. State 10b. County	10c. City, 1	Town or Location					10	Od. Inside City Limit	8
2 should be filed within 72 hours effer death with the Manyland and Mentel Hyggiene. Is marked other than "naturel", or frema 23a or 28a-f show aumatic event, the than "naturel", or frema 23a or 28a-f show aumatic event, the than "naturel", or frema 23a or 28a-f show aumatic event, the than "naturel", or frema 23a or 28a-f show aumatic event, the than "naturel" and "naturel". To Be Completed by Funeral Director	Maryland 10e. Street and Number	Balt	imore 10f. Zip	Codo			10g. Citizen of W	That Count	No Yes 2□ No	0
with with	1608 Normal Avenu			21213						
era era	11. Marital Status	12. Was Decedent Ever in U.S.				Specify Yes or No	U.S.,	A - America	an Indian,	
el', or items 23s or 28s-f show Examiner must be notified at by Funeral Director	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	It Yes, spec		Specify:	rto Rican, etc.)		bla		
ygiene. ser than "nature t, fre Wedical Completed	15. Decedent's Ed (Specify only highest gra-		16e. Decedent's Usua (Give kind of wo	l Occupa	tion	ndkina	16b. Kind of Bu	ainess/Ind	lustry	
be filed within 72 nd tel Hygiene. d other than "netuinevent, the Modical Be Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT us	se retired)	anny moor or we	Anti-g		struc		
Cor	12	0	Home In				Resider			
Be very	17. Father's Neme (First, Middle, Last)					me (First, Middle,		a)		
To atic	Milton James Payn					elma Lig				
th end Mer 7 Is marke traumatic	19a. Informent's Name/Relationship (7	ype, Print)	19b. Mailing Address	(Street e	nd Number or F	lural Route Numbe	er, City or Town,	Stete, Zip	Code)	
n 2 per	Angela M. Martise 20e. Method of Disposition	20b. Plac	1608 Norma te of Disposition (Nemoletery, cremetory or o	ne of		timore,	MD 212 20c. Location -		wn, State	_
Page int: if iry or	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify									
Department of Popularies I Items of Insportant: If Items any Injury or of	21. Signature of Funesal Service Licen	11 /20				rd, 655	W. Balti	more	Street	
-	23s. Pert1. Enter the disease, or comp	olicetions that caused the death.	Baltin Do not enter the mod			201 ac or respiratory e	rrest,		Approximete	
hysician	shock, or heart tailure. List only	one ceuse on each line.							Interval Between Onset and Death	
/Medical	immediate Ceuse (Final	R.Cell 1.	maha	ma				1	1 mbnou	/M
Examiner	disease or condition resulting in death)	e. B • CE// L	s e conseguence of).	11/1					intenou	yn
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cete be executed physician and s the buriel-trensit edical Examiner	Sequentially list conditions	b. Due to (or e	s e consequenca ot):							
an ar riel-t	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									
ling physicle se es the bur Medical	Cause (Disease or Injury that initiated events resulting in death) Last					-				
Jes th	resulting in death) Last									
ettending pl for use es ti for an/Med		d						1		-
od fo	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying c	ause give	n in Part I.	23b. Did	tobacco use cor	tributa to	the cause of deat	h?
igned by the ettenc be deteched for us by Physician	acromegali	1				10	Yes 2□ No	3 Prob	pably 4 Unkno	wn
been s should leted	Hypothypo	ideam			1,		en eutopsy rmed?	ava	ere autopsy tindings allable prior to mpletion of cause death?	
ate hes page 2	11 1					10	Yes 200No	1[Yes 2□ No	
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	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3□ DC	Othe	r _	Home 5 ☐ Resi		r (Specify		2
eral d	27. Manner of Death	28a. Date of Injury 28		8c. Injury Work			how injury occurr		HUSPIC	-
or death. by the fune	1 Natural 5 Pending investigation	(Month, Dey Year)	Injury M		res 2 No					
selected the selectors at Directors After the did by the funeral Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, ferm, street, factory	, office		28t. Location (City or To	Street and Numb wn, Stete)	er or Rura	I Route Number,	
Hospi 24 hou Funer Mely fill		ysician: To the best of my knowle ther: On the besis of examinetlor and manner steted.								
within 2 To the comple	29b. Signature end title of certitier		290	. License	number		29d. Date signed	(Month,	Dey, Year)	
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		0	L	110	, ,		April.	7//	11/	
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	PAVID KISEDER	9 30157	TAUI P	1	131	t/T/M	197	IIIL	77/20-	4
State	31. Dete tiled (Month, Day, Year)	32. Registrar's Signetur								

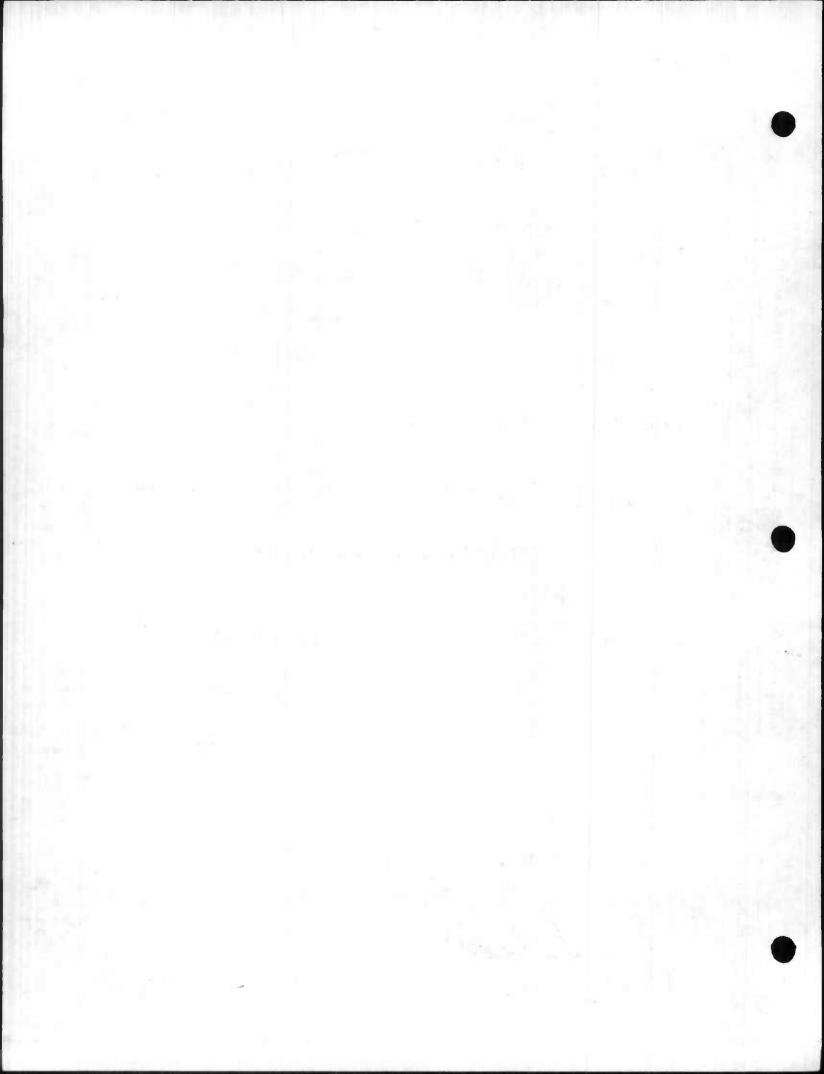


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State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedent's Neme (First, Middle	Last)					2. Date of D			Time of Death		
/Medical	Lucille Patte	rson					APRII	Day 22, 1	.999	0935 AM		
Examiner	4e Facility Name (If not institution,					4b. City, Town, or BALTIMO			ty of Death			
	827 NORTH ARI											
Funeral Director	5. Social Security Number 219-26-8358 Usual Residence of Decedent	6. Sex 7. A. 1 M 2 XF	ge (In yrs. la 6]	Mont	hs Days					(Stete or Foreign		
B W	10a. Stete 10b. County		10c. City,	Town or Location					10d.	Inside City Limits		
affed stor	Maryland		Balt	imore						1 ☑ Yes 2 ☐ No		
or 28a-f s be notified Director	10e. Street and Number			10f.	Zip Code			10g. Citizen o	What Country?			
ral la	827 N. Arlingto	n Avenue			212	217		U.S	.A.			
act within 72 hours, after death with the Marylar spices. If the Medical Examiner must be notified at it, the Medical Examiner must be notified at Completed by Funeral Director	11. Meritel Stetus 1 □ Never Merried 2 □ Merrie 3 □ Widowed 4 ☑ Divorced	12. Wes Decedent Armed Forces d 1 Yes 2 1 If Yes, Give Year or Detes:	?		scedent of l specify Cub s 2 1 No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	Spec	ace - American I ack, White, etc. ify: black			
	15. Decedent' (Specify only highest Elementary/Secondery (0-12)	grede completed) College (1-4or	5+)	(Give kind of life. DO NO	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Busin		ness/Industry		
	12 17. Father's Neme (First, Middle, L	0		Telephone operator				Commu		lons		
o Be	Willie Patterso	•				Bertha		o, many daring				
To	19a. Informent's Name/Reletionsh			19b. Meiling Addr	ess (Stree	tand Number or R		ber, City or Tow	n, State. Zio Coo	de)		
T Day	Eleanor Rollins			unknown	, , , , , ,							
ury or athe	20e. Method of Disposition 1 Buriel 2 Cremetion 4 Donation 5 Nother (Sp	3 □Removel from Stete	cer	ce of Disposition (netery, cremetory	Name of or other ple	oce)	Date	20c. Location	- City or Town,	State		
any inj	22. Name and Address of Facility Ronald S Wade Director State Anatomy Board, 655 W. Baltin Baltimore, MD 21201 23a. Kurll Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and only one cause on each line.									reet		
ian cal ner	Immediate Cause (Finet disease or condition resulting in death)	a Acquire		unodefic		Syndrome	2		1			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ь	Due to (or a	as a consequence	of):							
Physician/Medical Examin	Cause (Diseese or injury that initiated events resulting in death) Lest	c	Due to (or as e consequence of):									
cian	D. M. O. L. M		contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco						no use contribute to the series of death			
by Physician/M	Pert tt. Other algoriticant condition	a contributing to death t	but not result	ing in the underlying	ng cause gi	wen in Pert t.	23b. Did tobacco use contribu					
eted leted								24a. Was an autopsy performed? 24b. Were e available comple				
rector, page 2							10	Yes 2 No	1 D Y	s 2 No		
Be C	25. Wes case referred to medical exeminer?					26. Place of De	ath (Check only	one)				
To	XX Yes 2□ No	Hospitel: 1 ☐ tnpati			DOA		Home XX Res					
completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	27. Menner of Death Pending Accident Description 2 Accident Description 5 Could be	etion	by Year)	8b. Time of Injury	28c. Inju Wo	ry et ork?] Yes 2 ☐ No		how injury occ				
lled in by	3 ☐ Suicide 6 ☐ Could no determine	Could not be determined 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify)					281. Location City or To	(Street and Nui own, State)	nber or Rurel Ro	oule Number,		
pletely fil	29e. Certifier (Check only one) ID Certifying Medical E	Physician: To the best xaminer: On the basis of and menner s	of examinetic	edge, death occur in and/or investiga	red et the ti tion, in my	ime, date end place opinion, death occ	e, end due to the urred at the time	e cause(s) end e, date end plec	menner as state e, and due to the	d. o cause(s)		
§ 2	29b. Signature and title of certifier	1 1				se number		7	ned (Month, Day			
Med) Cambreles O.C.M.E								APRIL 23, 1999			
To the Funeral completely filled	· A Caru	to completed cause of	death (Item 2	(Type, Print)	0.	.C.M.E		APRIL	23, 199	99		

Registrar



Please Type or Print in Black indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM#7.8.&9 PER F.H. G771 5-14-99 J.A. Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death ROACH Month **Physician** HAZEL H.401.1 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALTIMORE HOSPITAL BON SE COURS | If Under 1 Year | If Undar 24 Hrs. | 8. Date of Birth 5-2(Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number -20-20 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□ F 213-26-2698 78 **Director** Usual Rasidanca of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Balton 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 is marked other than "natural", or items 23s or traumatic event, it a Medical Examinar must be i OAK AUE 2 1207 4.5 200 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaf, or items 23a any Injury or other traumatic event, it a Medical Examina main Funeral 14. Race - Americen Indian, Black, White, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 11. Marital Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Navar Married 2 Married BLACK Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) PRIVATE 124 Domestic 18. Mother's Name (First, Middle, Melden Surname) 17. Fathar's Nema (First, Middla, Last) JOHNSON BesSIE HORACE 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 2820 21207 RONA BALTO. Bernice A 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 1/17/99 Garrison Forest 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensaa 22. Nama and Addrass of Facility 23a. Perty. Enter the diseasa, or complications that ausad the death. Do not enter the mode of dying, such as cerdiac or respiratory shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner physician and the burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Ceusa (Disease or Injury that Initiated events rasulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): esn Part II. Other significent conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performad? page 2 certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: funeral director. 25. Was cesa rafarrad to medical examinar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1□ Yas 2☐ No 2 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Baath 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 -Natural 5 Panding Invastigation 24 hours after death. 1 Yas 2 Accidant 6 Could not be datarminad 3 Sulcide Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homlcida 29a. Certifiar 1 Certifying Physician: To tha best of my knowledge, deeth occurred et the tima, date end plece, end due to the ceuse(s) and menner es steted. Medical completely (Check only one) 2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. within 2 To the 29b. Signature and titla of certifia 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

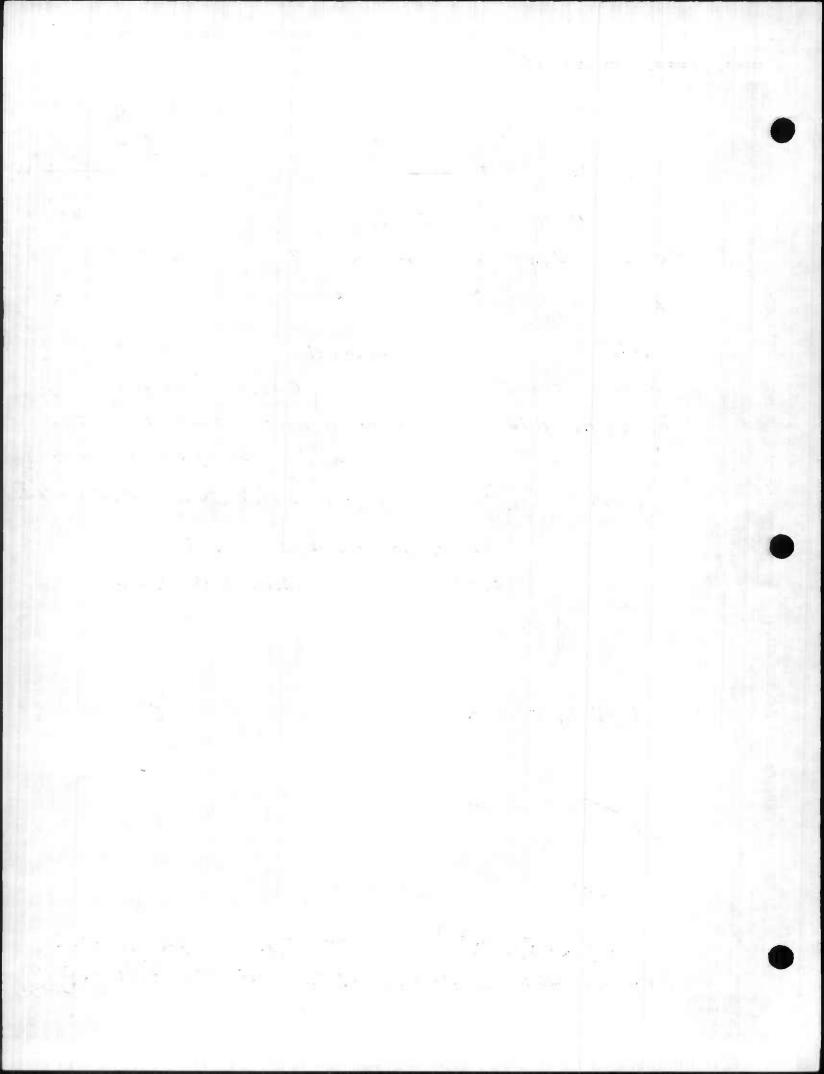
KEARNEY

32. Penistrar's Signatura

State Registrar

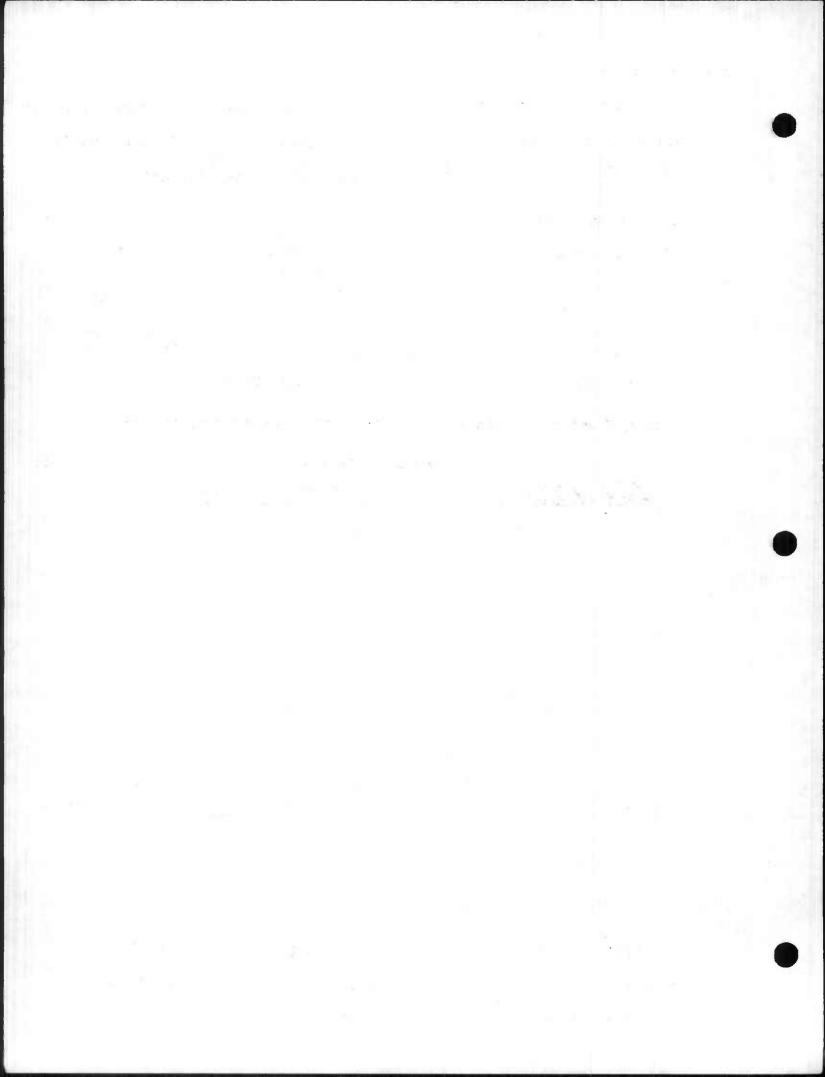
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31. Data filad (A



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Ame	nde	d#26 perPhyG771 5/14/9		Marylar	nd / Depa <i>Cer</i>	irtment of tificate of	Health and Death	Mental Hy	rgiene	15	733	
Physic /Medi		1. Decedant's Nama (First, Middla, La Mary Kathlee	*	ans				2. Date of De Month May	Day	Year 999	3. Time of Death 8:30 P.M	
Exami		4a. Facility Name (If not institution, given 12315 Starlight 1		per)			4b. City, Town, o	or Location of Deat	ocation of Death 4c. County of Death Prince George			
Funeral Director		5. Social Security Number 213 58 9505 6. S		Aga (In yrs. 48	last birthday) Yrs.	If Under 1 Yea Months Days		n. (Month, Di		9. Birthpla Country	ce (State or Foreign	
yland		Usual Rasidance of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				100	d. Insida City Limits	
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3a or 2	JO Je	10e. Street and Number 1722 Dana Street				10f. Zip Coda	21114		10g. Citizan of V United			
17215-U020 within 72 hours after death with the Meryland she. then "natural", or ttems 23s or 28s-f show then "natural" or the second of the Medical Examiner must be recorded at	by Funeral Director	11. Marital Status 1 Nevar Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yas 2 If Yes, Give Year or Date	es?		Vas Decedant of Yes, specify Cu		(Specify Yes or No arto Rican, etc.)	5- 14. Rac Blac Specify	e - Amarica ck, Whita, et	c.	
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours after death with the Merylan Department of Heelth end Mentel Hyglene. Important: if Item 27 is marked other than "natural", or thems 23s or 28s-f show shy living or other treumetic event, the Medical Examiner must be nounted at once.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation		(Give I		upation a <i>during</i> most of w ed)	vorking	16b. Kind of Bu Prince County			
Vland in inches	To Be Co	17. Father's Nama (First, Middle, Last Harry J. McMaho				cher		ame (First, Middle Mooney	, Maiden Sumam	10)		
Mary 12 sho h end !	ľ	19a. Informant's Name/Ralationship (1				Rural Routa Numb	-	State, Zip 0	Coda)	
Baltimore, lemit. Peges 1 end Department of Heelt moortant: If item 21 nny injury or other ance.		Anthony Rosekran		20b. F			ace) May 1	ofton Mar 2, P999	20c. Location -		n, State	
Li Pege Iment Iment Itant: If		1 ☐ Burial 五 Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	<i>y</i>)	ala	ropoli	tan Cre	natory		Alexan	dria V	/irginia	
Ball permit Depar Impor		22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate										
Physician //Medical pe executed Examiner Shysician and se the prinel-transit	dical Examiner	Immediate Causa (Final diseasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initiated evants	a	Dua to (d	or as a consequence as	uance of):	ルビンへ				Onsat and Death	
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DIVISION O To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Certification:	Z LI Accidant	3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office						8f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
To the Hospital within 24 hours To the Funeral I completely filled	edical (29e. Certifiar (Check only one) 12 Certifying Ph	ysician: To the be	s of axamina	wledga, daath tion and/or Inv	occurred at that estigetion, in my	tima, deta end ple opinion, death oc	ce, end due to the curred at tha tima,	causa(s) and ma data and place,	innar as stated	led. he cause(s)	
within: To the	Mec	290. Signature and title of certifier	ano manna	Stated.		29c. Licer	nse number		29d. Date signe	d (Month, D	ay, Year)	
		1 41-7	7			M	D1832	٥	5/7/0	39.		
		30. Nama and addrass of person who	1		n 23e) (Type, F	Print)	(65747	Baltin	ion 1	0 21	287.	
Sta Registi		31. Data filed (Month, Day, Year)		istrar's Signa	b.	Spark						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 2. Data of Death o, Last) Day 1999 **Physician** 0 Ma AY /Medical vo, or Location of Examiner 8. Data of Birth Month, Day 9. Birthplaca (State or Foraign S. Carolina) 7. Age (In yzs. lest birthday) **Funeral** Days 1 M 200F 22-2659 Director Usual Residence of Decedent d 2 should be filed within 72 hours efter deeth with the Maryland th and Mantal Hygiene.
7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Evaprime, must be notified at 10c. City, Town or Location 10a Stata 10b County 10d. Inside City Limits 1 Yas 2 No Funeral Director Street and Number 10f. Zip Code 10g. Citizan of What Country? 12. Was Dacedant Evar in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-II Yas, specify Cyban, Maxican, Puarto Rican, atc.) Amarican Indian 11. Marital Status Black, Whita, etc. 1 ☐ Navar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedant's Usual Occupation
(Giva kind of work done during most of working lifta. DO NOT use retired)

OUSEWIFE Be Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elemantary/Sacondary (0-12) Collaga (1-4or 5+) Mothar's Nama (First, Middla, Maldan Sumama) Fathar's Nama (First, Middla, Last Peges 1 end 2 should be nent of Heelth end Mental or Rural Route Number, City or Town, State, Zip Coda) Important: If Item 27 is any injury or other trees-20a. Mathod of Disposition 20b. Place of Disposition Town, Steta 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Ligensee 10, Part . Enter tha disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory lock, or heart failure. List only one ceuse on each line. Approximata Interval Batween Onsat and Deeth **Physician** /Medical Immediete Cause (Finel GASTROINTESTINAL BLEED disaasa or condition rasulting in death) Examiner Examiner The lew requires that the death certificete be executed ettending physicien and for use es the burief-trensit Sequentially list conditions, if any, laading to Immadiate causa. Entar Underlying Causa (Diseasa or Injury that initiated avants rasulting In daath) Last Dua to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 1 Yes 2 No 3 Probably 4 Unknown AND THORACIC ANEURYSM p 24b. Wera autopsy lindings available prior to completion of ceuse of death? Completed 24a. Wes an eutopsy HYPERTENSION is certificate has I director, page 2 s 2 No 1 Yas 2 No 1 ☐ Yas Division of Vital or Attending Physicien: Be 25. Was cesa ralarrad to medical examiner? 28. Pleca of Deeth (Check only ona) Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify) 1 Yas 2 No 1- Inpatiant Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Mannacol Death 28a. Date of Injury (Month, Dey Yaar) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After 5 Pending Invastigation 1 Naturel Injury 1 Yas 2 No death. 2 Accidant Director: / 3 Suicida 6 ☐ Could not be datarminad Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, larm, straet, lactory, office building, atc. (Specify) 4 - Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in Lecrtifying Physician: To the best of my knowledge, death occurred at tha time, deta end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. Medical 29a. Cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian mille 030272 30. Nama and addrass of person who complated causa of daath (itam 23a) (Type, Print)

State Registrar 31. Deta filad (Month, Dey, Year) MAY 1 4 1999

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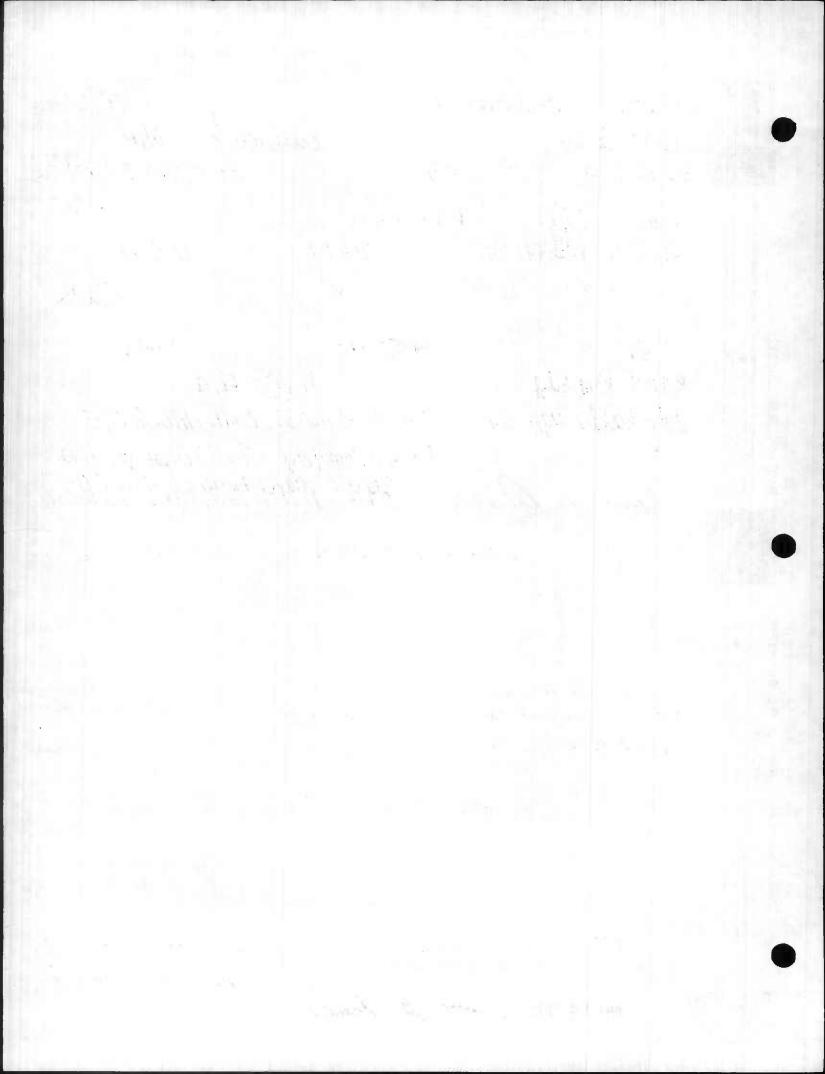
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MILLEN 32. Ragistrar's Signatura

Sparks

BACTIMORE, MD

HOSPITAL



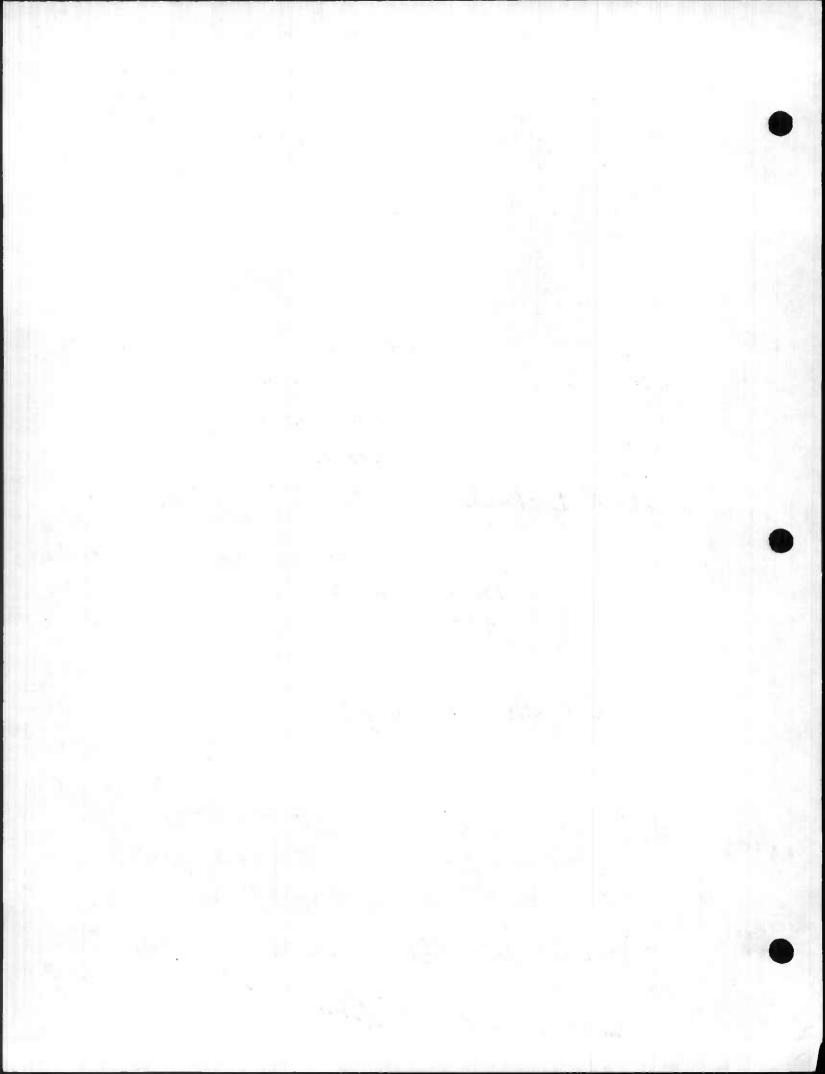
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Paul David Schultze May 1999 6, 2:20 am /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Rossville Rosedale Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 11XM 2□ F 218 76 6405 39 Director Maryland Jan. 31,1960 Usual Rasidence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or llams 23s or 25s-f shor the Medical Examiner must be notified at the Maryt Maryland N/A Baltimore 1X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2008 East Pratt Street 21231 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, 11 Marital Status Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Craft Maker Home Decorations 11 permit. Pages 1 and 2 should be filled. Department of Health and Mental Hygie Important: if from 27 is marked other: any injury or other traumatic event, it 17. Father's Name (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be William R. Schultze Sr. Dorothy Toft 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William R. Schultze Jr. (Brother) 1045 Foxwood Lane Baltimore, Md. 21221 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Crematory 5/7/1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Ligur 22. Nama and Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 OLd Eastern Avenue Essex, Md. Entar the disease, or complications thet caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, or heart teilura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Examiner uno/hora burial-transit Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last and Due to (or as a consequence of): that the death certificate be exec attending physician for use as the buria Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23h. Did tobacco use contribute to the cause of death? signed by t rypto coccal 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records. þ 24a. Wes an autopsy performed? 24b. Wara autopsy tindings availabla prior to completion of cause of death? Completed peed certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Wes case retarred to medical Be 26. Place of Death (Check only ona) axaminar? Other: 49 Nursing Homa 5 Residence 8 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation Naturat 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) illed in by 4 Homicide Medical Examiner: On the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Sut 3 Balhmore, MD 21218 MUEL J. WESTRICK State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 330AM May Dorothy Smith 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Baltimore Crty Jaryland General N/A If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Deys 1 M 2 G 131-01-2774 New York Aug. 19,1911 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. fnslde City Limits 1X Yes 2□ No N/A Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 301 McMechan Street 21227 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2√ No Specify: Specify. 3XXVidowed 4 □ Divorced Black Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Clothing Seamstress 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) N/A N/A 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6276 Golden Hook, Columbia, Md. 21044 Clarissa Evans 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Balto.-Wash. Crematory Laurel, Md. 22. Neme and Address of Fecility 21. Signature of Furfecal Service Licensee Bradley-Ashton-Matthews Funeral Home Inc. 238. Part! Enter the disease, or semplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximete Intervel Between Onset end Deeth Theumonia Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Dronknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings eveileble prior to 24a. Was en eutopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA

Examiner sician and buriel-transit physician sthe buriel ed by the a signed by d be detacl

Physician

/Medical

Examiner

Director

Funeral

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Director

7 is marked other than "natural", or fems 23s or 28s-f show traumstic event, the Medical Expriner must be notified at

permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Me. ORCE.

Physician

/Medical

JOROTHY Drit

Examiner peen funeral After

Physician/Medical p Completed Be 2 27. Menner of Deeth Certification:

Medical

Box 68760 P.0. Records, Division of Vital death. i or Attend after death Director: / To the Hospital or Atterview within 24 hours after der To the Funeral Directo completely filled in by the

> State Registrar

31. Dete filed (Month, Day Year) MAY 1 4 1999

29b. Signeture end title of certifier

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print). Yo paryland General Hospital 32. Registrer's Signature

28e. Dete of Injury (Month, Dey Year)

28b. Time of

M. D.

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. tnjury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29c. License number

1 Yes 2 No

712677

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

1 (Neturel

2 Accident

3 Sulcide

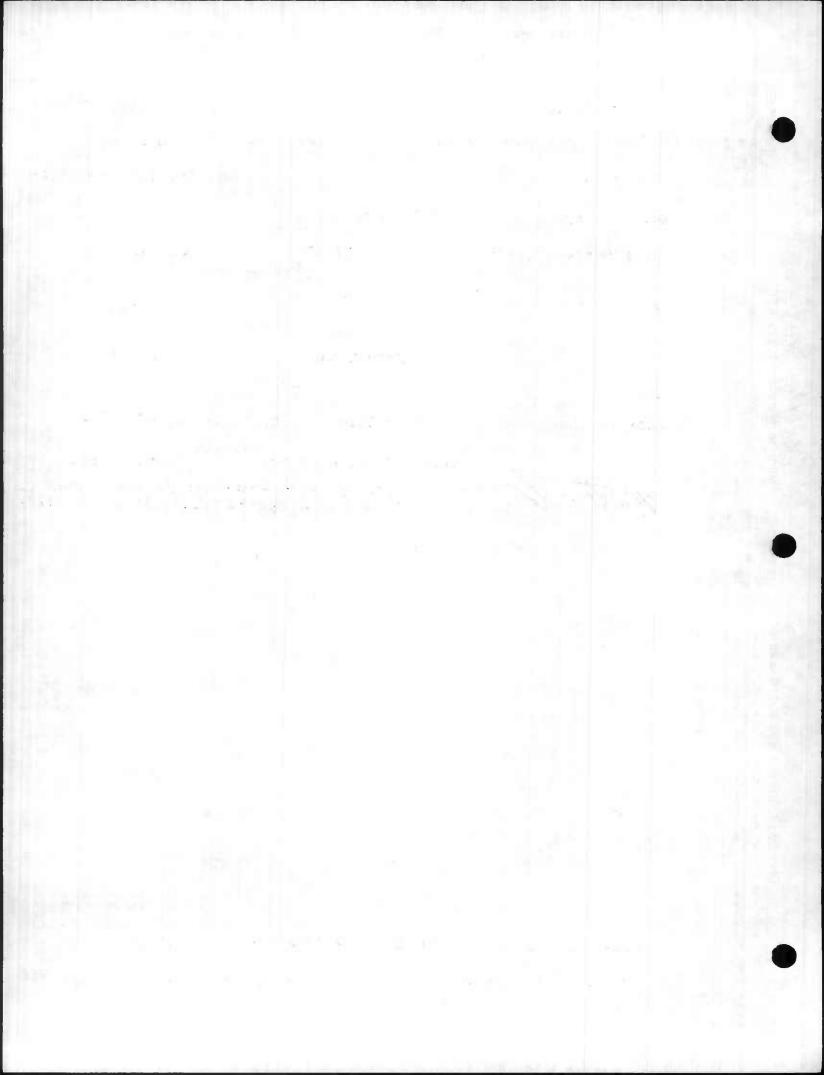
29e. Certifier

4 Homlcide

5 Pending

Investigation

6 Could not be determined



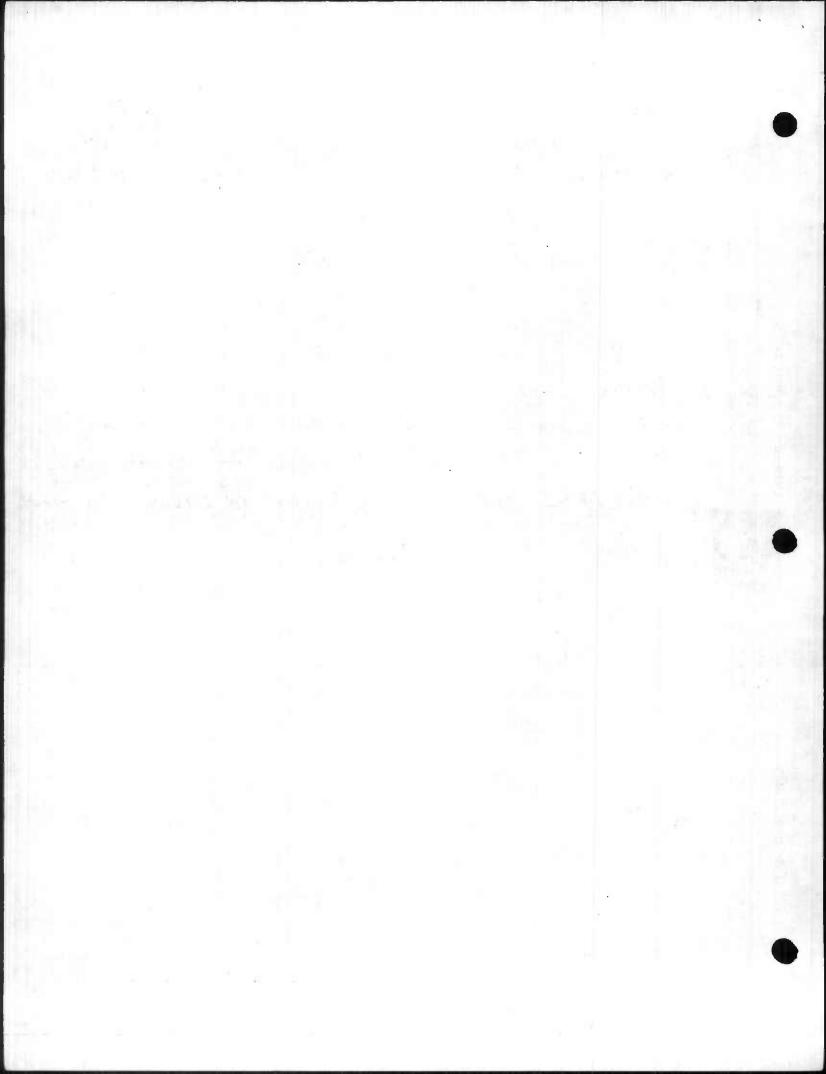
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** a /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Yea 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 216 10 M 20 F Yrs Director de Usual Residence of Deceden permit. Pages 1 and 2 should be lited within 72 hours effer death with the Meryland Department of Health and Mentel Lyglans. Important: if Item 27 is marked other than "naturel", or Itema 23a or 28a-1 about the BODS. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 236 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Status 1 Never Married 2 Married 1□ Yes 2 No Specity: White Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Surname) 8 OL. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 21236 Mith 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Fecility 8 Valus 8800 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Colon disease or condition resulting in death) conce Examiner Due to (or as e consequence of) Examiner physician end s the burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or as e consequence of): for use signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 3 Probably 45 Unknown 1 Yes 2 No þ or Attending Physician: The law requires 24b. Were autopsy findings svailable prior to completion of cause of death? should I 24a. Wes an eutopsy performed? Be Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director. 25. Was case referred to medicet 26. Place of Deeth (Check only one) 1 Yas No Other: 4 Nursing Home Certification: To 5 Residenca 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this lunerei 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending 1 Natural 1 Yes 2 No n 24 hours after deeth.

Ne Funerel Director: A
pletely filled in by the I deeth. investigetion 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 29e. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. completely (Check only one) 2 Medical Examiner: On the besis of examend manner stated. minetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) To the To the To the F 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 16587 5/12 Yau pleted cause of death (Item 23a) (Type, Print) me and address of person 560

State Registrar

32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

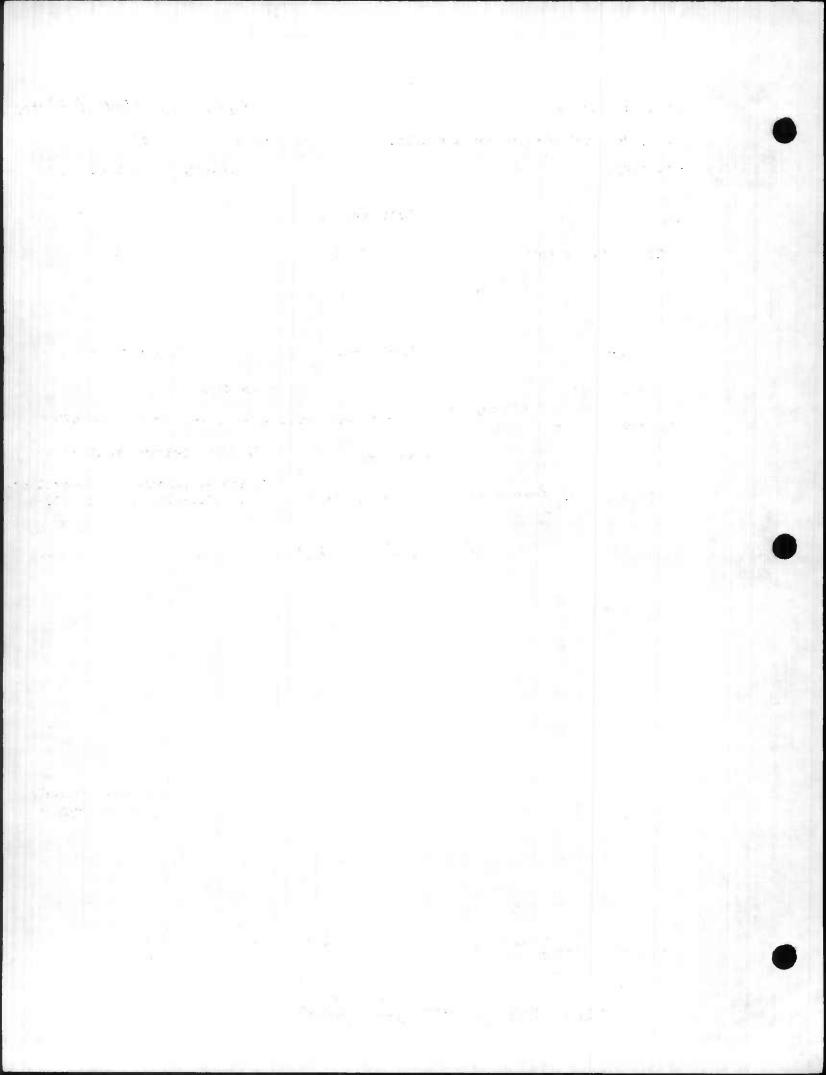
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Nicholas Storto 10:40 AM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Hospital -Stella Maris Hospice Baltimore n/a 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 4-6-1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MM 2□ F Months Days Hours 212-20-5235 75 Yrs. Baltimore, MD Director Usual Rasidance of Decedent with the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinal must be notified at Baltimore 1 ☑ Yes 2 ☐ No Director n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3025 Eastern Avenue 21224 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕱 No Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Meritel Stetus Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours efter to Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or item 1 ☐ Never Married 2K Married White Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondery (0-12) Coilege (1-4or 5+) Store owner Self employed 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Pasquale Storto Caterina Corsi 2 19a. Informent's Name/Relationship (Typa, Print) daughter 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 317 West Grand Avenue, Apt. 4-B Rahway, NJ 07065 Taylor other 1 Barbara 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) Dete 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removel from Stata 5/15/99 Injury or Baltimore, Maryland Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signeture of Funeral Service Licensee Marca A. Zanniso

263 S. Conkling St., Baltimo

263 S. Conkling St., Baltimo

264 Shock, or heart failure. List only one cause on each line. Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St., Baltimore, Maryland 21224 Approximate Interval Between Onset end Death **Physician** /Medical Immediate Causa (Final disease or condition resulting in deeth) Colon Conse + tustate mhrom Examiner Due to (or as a consequence of) Examiner physicien end s the buriel-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in daath) Last Due to (or es a consequença of): P.O. Box 68760 requires that the death certificete be Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 3 signed b Division of Vital Records, p 24b. Ware autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy peeu hes page 2 certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certific funeral director, 26. Plece of Death (Check only one) SELIA MATIS HINKLY 25. Was case referred to medical examiner? Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSPI (2 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? Naturel 5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 4 | Homicida 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the causa(s) and mannar as stated.

Madical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and menner stated. edicai 29a. Certifier To the Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D40854 M 13 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 01 301 5+ Pul lusevery usut 31. Dete filed (Month, Dey, Year) 32. Registrar's Signetura Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Day **Physician** 45 Kosemany Schaffer 2 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE NURSING CENTER N/A BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-28-22 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2□ F 76 Yrs. 220-12-5072 **Director** N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo N/A BALTIMORE or 28a-t 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 12 N. BENTLOU ST. 21223 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Å 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: A 3X Widowed 4 ☐ Divorced BLACK Year or Dates: Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) -8--0-DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Pages 1 and 2 should be nent of Health and Mental UNKNOWN OZELLA BOOZER 2 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If them 27 is any injury or other trau 12 N. BENTLOU ST. BALTIMORE, MARYLAND 21223 CATHERINE HOLMES (DAUGHTER) 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☑Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata BALTIMORE NATIONAL CEM. 5-18-99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PHILLIPS FUNERAL HOME. P. A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 CFSA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner die VAscalar dece The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to Immediata cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the burial-tran P.O. Box 68760 Physician/Medical Due to (or as a consequence of): USB as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached is certificate has been signed by director, page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy findings available prior to Be Completed 24e. Wes an autopsy completion of cause of death? certificate has 1□ Yes 2⊡No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To this funeral 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 2 Accident A Hospital or A. 24 hours after death. 1 Yes 2 No 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Buls St Reistudous HARD LD

DHMH 16 Rev 6/95

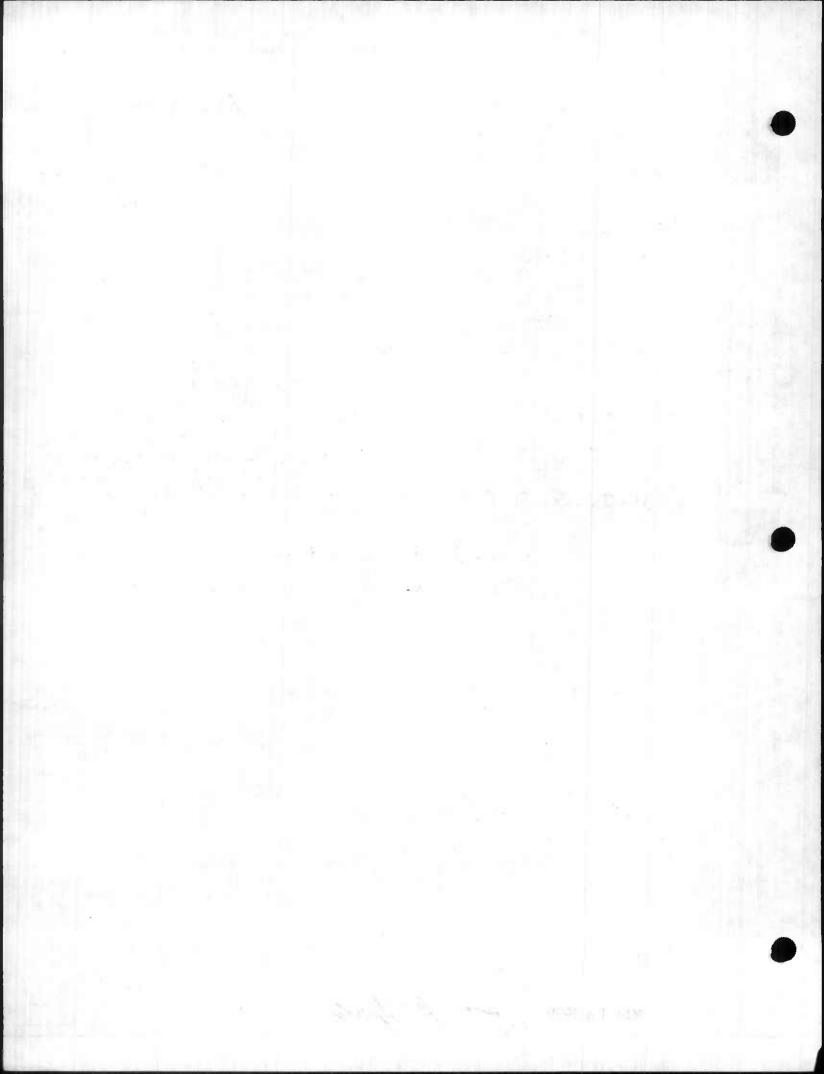
State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 4 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death Robyn Lynn Seybrecht 1999 MAY 10 3:35 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 20 F Months Days Hours 216-82-2080 Yrs. Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Cecil Conowingo 1 ☐ Yes X☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Highview Road 21918 USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Jay Baird Roberta Kachel 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott A. Seybrecht/husband 25 Highview Rd. Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 【Cramation 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Metro Crematory, Inc. 05/12/99 Baltimore, MD 22. Name end Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 21. Signeture of Funerel Sarvice License Edu Edward A. egorchik 299 Frederick Rd. Balting 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart fellure. List only one cause on each line. Approximata Interval Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in deeth) UPPER GASTROINTESTINAL BLEEDING 2 HOURS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE 24b. Were eutopsy findings available prior to completion of cause of death? CIRRHOSIS OF LIVER. 24a. Was an autopsy performed? PNEUMONIA, BILATERAL 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽ No 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 DiNaturel 5 Pending

Examiner Division death. 24 hours after deat Funeral Director: Hospital

Examine

Physician

/Medical

Examiner

MD

Funeral

Director

r items 23s or 28s-f show

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene.

Int: If Itsm 27 Is marked other than "natural", or itema 23s or Lay or other traumatic syent, the Medical Examinar must be a

Important: If Item. any Injury or othe

Physician

/Medical

Director

by

Physician/Medical by Completed Certification: To Be

edical To the Hosp within 24 hos To the Fune completely fi

State

Registrar

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signetura and titla of certifier

31. Date filed (Month, Day, Year) 32. Registra signature

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) DOSO96 MAY 10, 1999

28t. Location (Street and Number or Rural Route Number, City or Town, State)

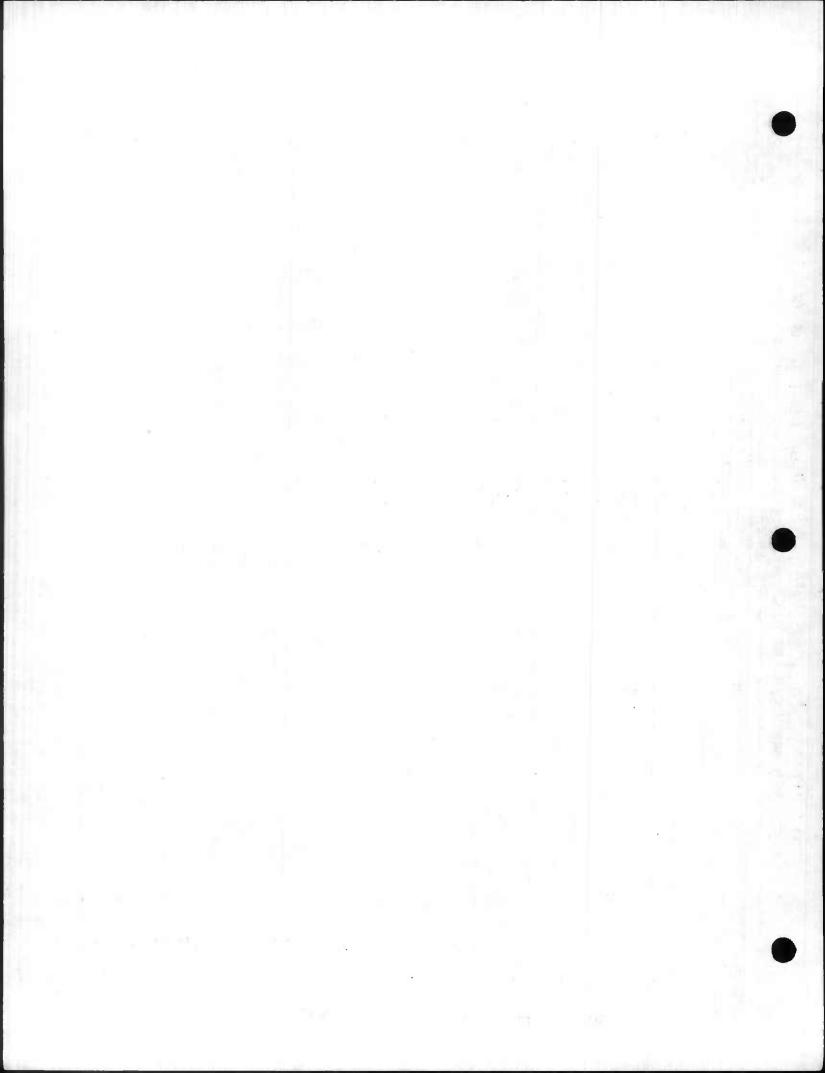
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDRON NOWAKOWSKI

de Nowaling un

6 Could not be determined

125 N. MAIN ST. BEZ ATR, MD21014

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician ğ William Edward Sears 1999 May 10:15 pm /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Deys Yrs 60 216-34-1615 Aug. 21,1938 **Director** Maryland Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 25s-4 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 16 Marbury Court 21032 Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1X) Yes 2 □ No If Yes, Give Year or Detes:1956-59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Meritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mantal Hygiene. Important: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 10 Maintenance Chief State of Maryland 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) F. Lee Sears Myrtle P. Griffith 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Donald Sears (Brother) 225 Circle Road, Pasadena, MD 21122 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriel 2 Cremetion 3 Removel from State injury or 4 ☐ Donetion 5 ☐ Other (Specify) Lakemont Memorial Gardens 05/13 Davidsonville, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses any ir 12 Ridgely Avenue, Annapolis, MD 21401 alm 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or es a consequence of): Examine certificata be executed ettending physician and for use as the bunal-tran Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequence of) SE 23b. Did tobacco use contribute to the cause of desth? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. detached the signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings aveilable prior to Completed 24e. Wes en eutopsy peed completion of ceuse of death? page 2 s has 20 No 1 Yes certificate 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Be Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Depatient 10 2 ER/Outpetient 3 DOA Aftar this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: or Attending 1 Natural 5 Pending 24 hours efter death. 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completaly (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the Vithin 2 29d Dete signed (Month, Dey, Year) 29b. Signature and the of ce 29c. License number mL 30. Name end eddress of person who completed cause of deeth (16m 23a) (Type, Print) #12/ Annapalis ENJ/ FIN

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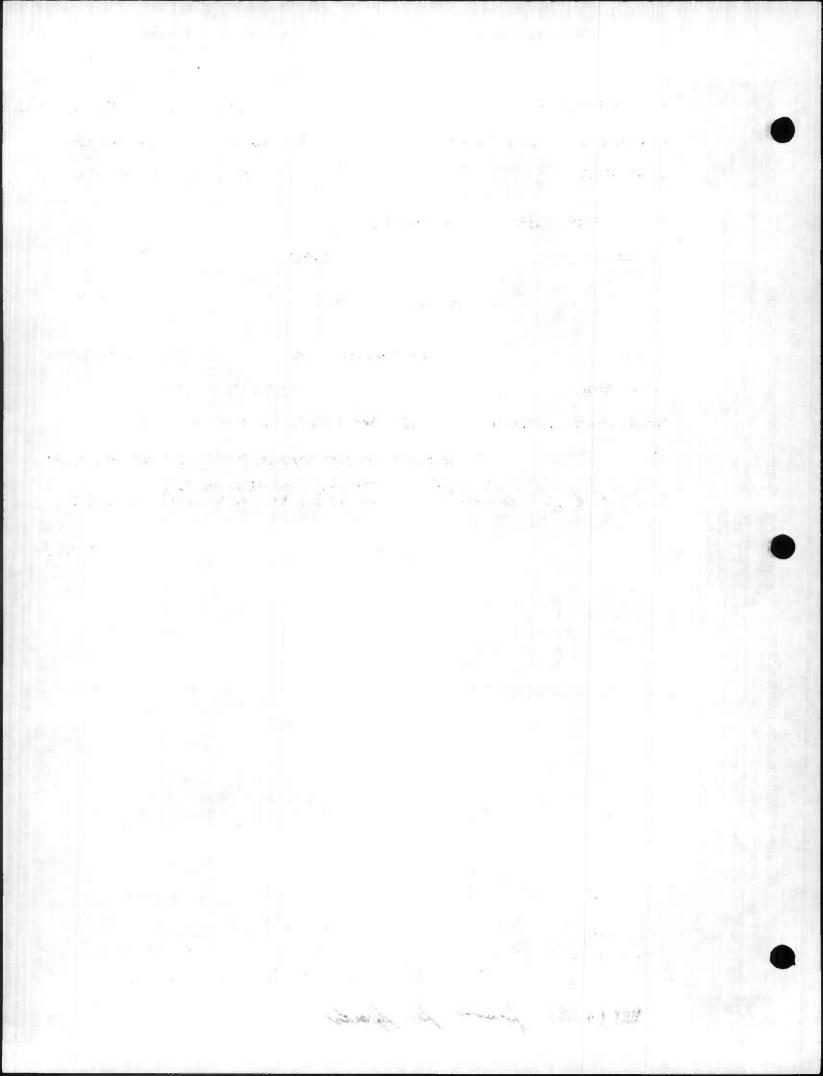
State Registrar 31. Dete filed (Month, Day, Yeer)

MAY 1 4 1999

32. Registrer's Signeture

Sports

DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 0737 lentine 1999 May 4a. Facility Nama (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Bayview Baltimore Medical NIA topkins Johns 8. Data of Bilth (Month, Day, Year) If Under 1 Yaar Months Days 6. Sax 5. Social Security Numbar 7. Aga (In yrs. lest birthday) If Undar 24 Hrs. Birthplace (State or Foreign Country) 12 M 2□F Days Hours Mary land 220-22-3188 Usuel Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Mary land Baltimore bundalk 1 ☐ Yes 2 ☑No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ton 21222 40 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Giva Was Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 11. Marital Status 14. Rece -American Indian Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Whi Specify If Yas, Giva Yaar or Detas: Specify: 3 ☐ Widowed 4 ☑ Divorcad 18e. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coilage (1-4or 5+) Sergeant U.S. Military 12 years 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) Solomon E. Seifert Emma S. Engelhardt 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Ms Valerie C. Thornton/Friend 1923 Inverton Road Baltimore, Maryland 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Garrision Forest V.A.Cem, 5/13/99 Owings, Mills, MD 21. Signature of Junaral Service Licanse 22. Name end Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the deaso, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heer dealines. Approximata Intarvai Batween Onsat and Deeth Immediata Causa (Finel diseasa or condition resulting in daath) Dua to (or es a consaquence of) rene 01 Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disaasa or Injury that initioted avants resulting in death) Lest Dua to (or as a consequanca of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailebla prior to completion of cause of death? 24a. Was en eutopsy performed? 2 No 200 No 1 Yas 1 Yes 25. Was casa rafarred to medical 26. Pleca of Daath (Check only ona) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturai

Box 68760, of Vital Records, P.O. Division death.

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician end the bunel-transit is certificate has been signed by the ettending p director, page 2 should be detached for use es After this certificate has filled in by the funerel Certification: s efter death

Physician/Medical Be Completed by P

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò items 23a Director

Funeral

by

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the Marviend

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Pages 1 end 2 should be filed within 72 hours after of nent of Health end Mentel Hygiene. Int: If Item 27 is marked other then "natural", or ite

Depertment of Health er Important: If Item 27 is any injury or other trau

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

4 Homicida Medical 29a. Cartifiar 29b. Signatura and title of cartifie

2 Accident

3 Sulcida

5 Panding invastigation

6 Could not be datermined

28a. Pleca of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

1 Yas 2 No

1 Certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, deta and placa, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

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29d. Deta signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

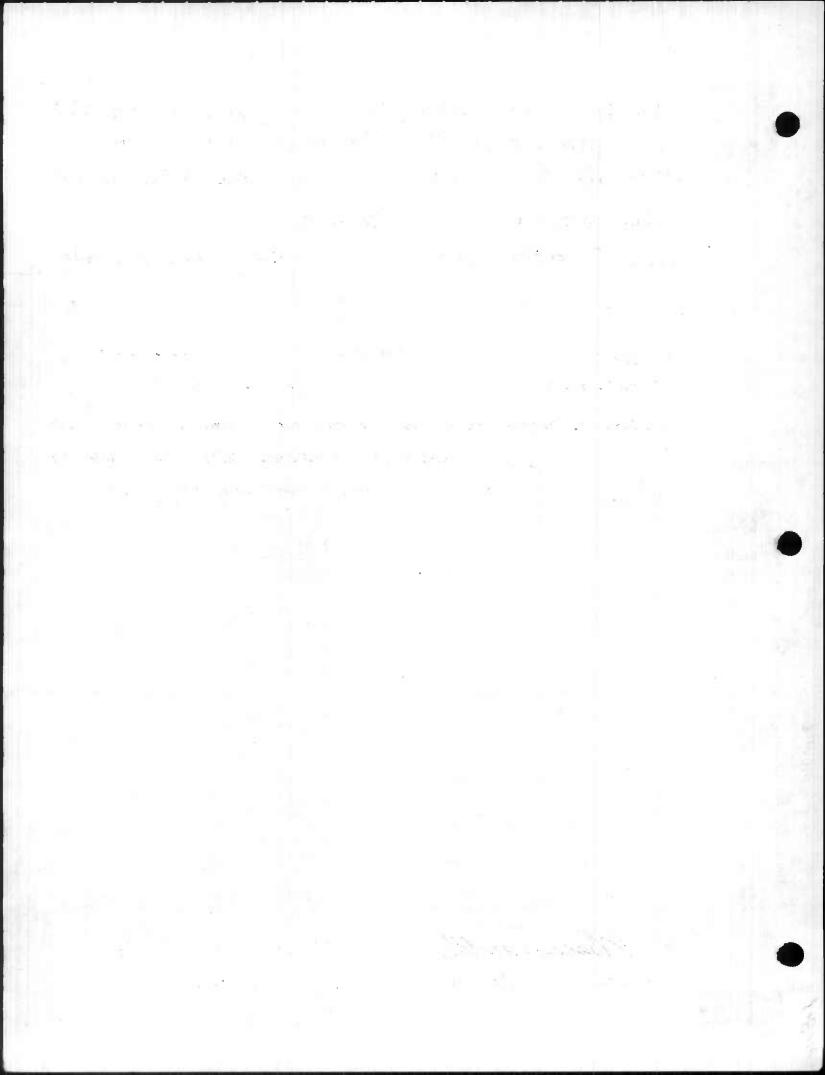
30. Name and address of person who completed daath (Item 23e) (Type, Print) DWARD BESSMAN

31. Dete filed

32. Registrar's Signatura

State Registrar

To the Hospital within 24 hours e



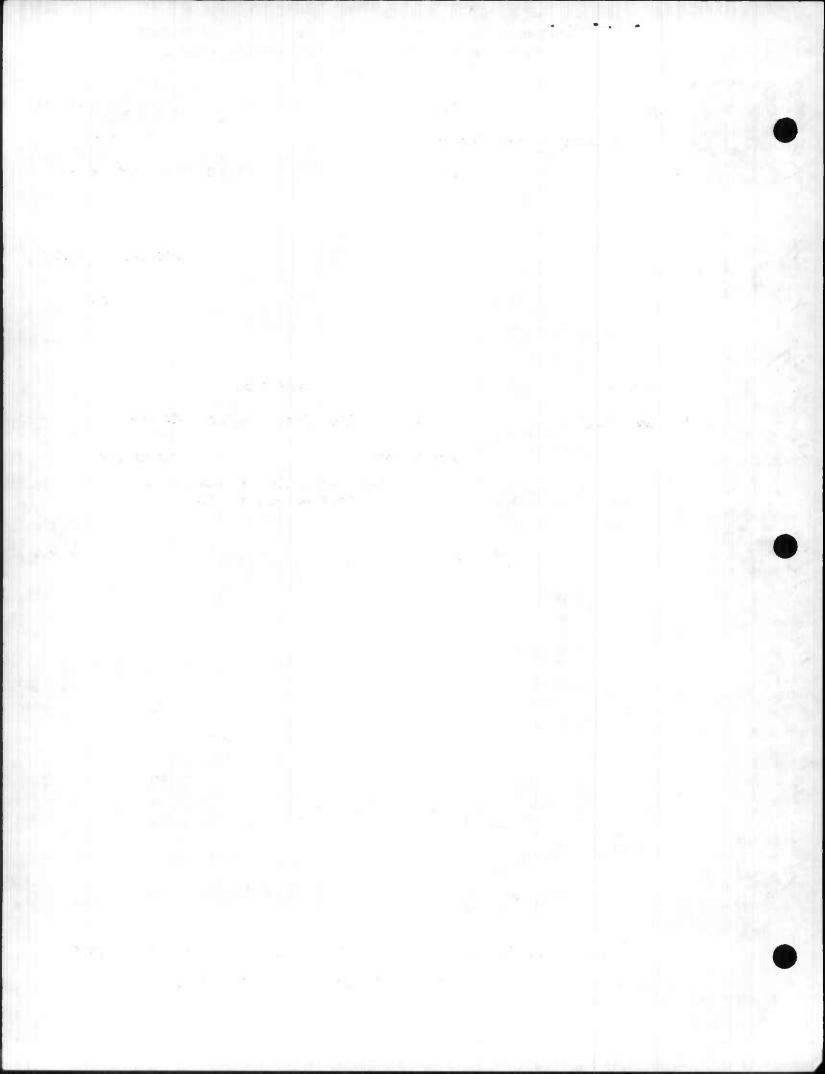
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 1999 9:15 PM SAUL May 10, HINE /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Towson Baltimore Dulaney Towson Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Birthplace (Stete or Foreign
Country) **Funeral** 1 M 2 XF Months Deys Hours Yrs. June 06, 213-48-8175 78 Kutztown, Pa. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Maryland Directo Baltimore Towson 10a. Street and Number 10f. Zlp Code 10g. Citizen of What Country? b traumetic event, the Medical Examiner must be Harrie 23a 111 West Rd. 21204 United States of America Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☐ Married 1 Tes 2 No Specify: ģ Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Public Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Lovina Herbein Earl Schaeffer 19a. Intorment's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Steven Saul(Son) Towson, Maryland 21286-7805 Important: If Item 27 403 Aigburth Rd. 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Hope Cemetery Kutztown, Pa. 5/14/99 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service LAST 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Bety Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ZHRIMERS DISEASE
Due to (or as a consequence of): Examiner Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last gud Due to (or as a consequence ot). Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yee 2 No þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 25 de 1 ☐ Yes 2 ☐ No 25. Was cese reterred to medical examiner? Be 26. Plece of Death (Check only one) · To Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 켩 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Division Natural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 0 12039 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) WALTER R. WELZANT MD 7600 OSLER DR STE 107 TOWSON, MD. 21204

Registrar

31. Dete tiled (Month, Dey, Year) MAY 14 1999 32. Registrar's Signature

DHMH 16 Rev 6/95



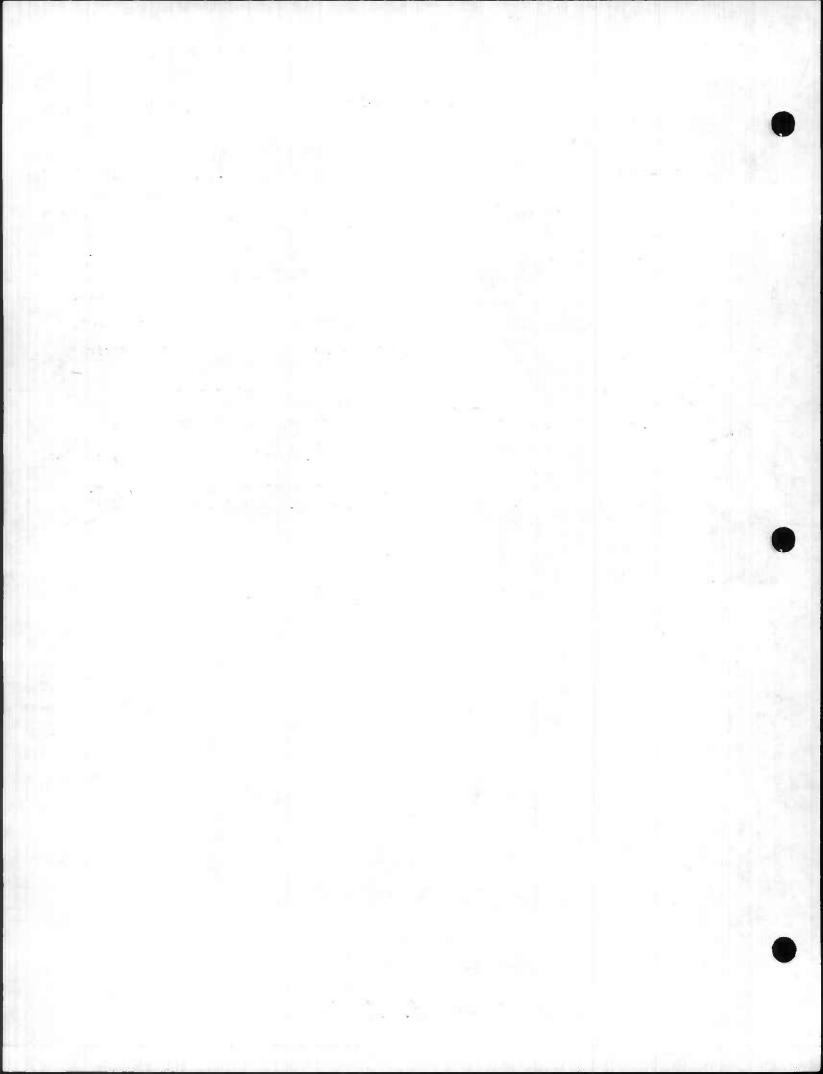
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State of Maryland / Department of Health and Mental Hygiene

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Funera Directo		5. Social Security Number 6. 213-44-9262	Sex 1□M 2√2F	7. Age (In yrs 56	. last birthday, Yrs.) If Unde Months	Days		Min.	8. Data of Bir (Month, Da Nov. 8			_	ate or Foreign
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72 hours effer death with the Maryland natural, or flams 23a or 28a-1 show deat Examiner must be podified at	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 XWidowed 4 Divorced	12. Was Dec Armed F 1 Yas if Yas. G	12. Was Decedent Ever in U,S. Armed Forcas? 1 Yas 2 No if Yas, Giva Yaar or Datas:		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican □ Yes 2 □ XNo Specify:					14. Ra Bla Speci	ick, Whita,	a - American Indian, k, Whita, atc. White	
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artificate be ex ing physician e as the buriel	Medical													
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l or Attending after death. Director: After d in by the fune	Certification:	2 Novice S Could get be						28f. Location (Street and Number or Rural Route Number, City or Town, State)				Number,		
Hospita 24 hours Funeral staly fille	edical C	29a. Certifler Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one Check only Check only one Ch											ise(s)	
within 2 To the comple	≥	29b. Signatura and title of certifier	and mai	nnar stated.		29	c. Licen	se number			29d. Date sign	ed (Month	Day, Ya	ar)
Viti To		D14221 5.12.									-			
		30. Nama and addrass of person wh	completed cau	usa of death (Te	m 23a) (Type	, Print)	24	0 1	A-17	- 625	2,1	2-1		
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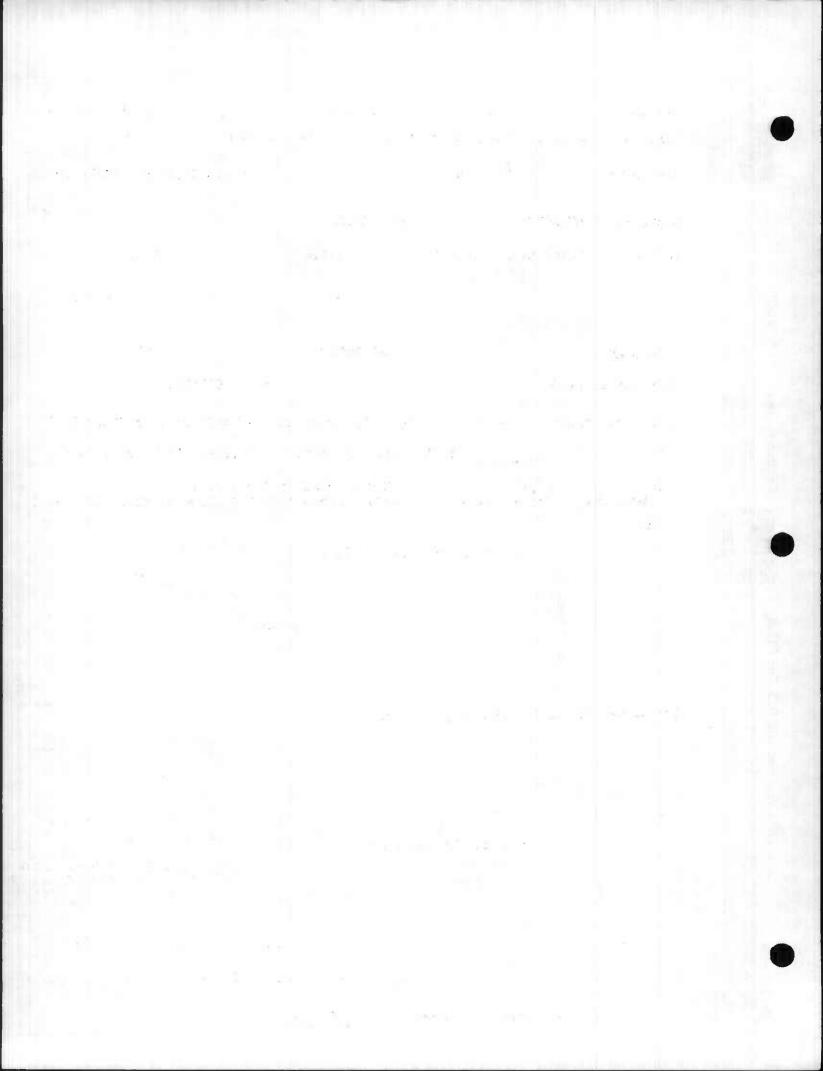
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Yee **Physician** Helen Stolte 4b. City, Town, or Location of Death 1999 16:34 /Medical 4e Facility Name (If not Institution, give street and number) 4c. County of Death Univ. of Maryland Medical System Baltimore N/A 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1 M 2 XF Yrs Director 216-03-0329 APRIL 24,1919 MARYLAND Usuei Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. inside City Limits Show r than "natural", or items 23a or 28a-1 show 1 Yes 27 No Directo MARYLAND BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 707 MAIDEN CHOICE LANE - APT-9220 21228 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Divorced 4 Divorced Year or Dates: WHITE Completed 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is merked oth eny Injury or other treumetic event page. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be CLARENCE B. KING AMANDA O'RILEY 19e, Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ARTHUR M. STOLTE, JR. (SON) 6309 JOHNNYCAKE ROAD - BALTIMORE, MARYLAND 21207 altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify Mausoleum LOUDON PARK CEMETERY 5/11/99 BALTIMORE, MARYLAND 21. Signety e of Funeral Service Licenses 22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. uanita Homos 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Then the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medicai Immediate Cause (Finel Probable Pulmonary Embolism (clinical) disease or condition resulting in deeth) THE WESTERN WE MEDICAL EXAMINER Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last physician and the burial-tran Due to (or as a consequence of) certificate be exec Physician/Medical Due to (or as a consequence of) SE for use as 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. signed by t 1 Yss 2 No 3 Probably 4 V Unknown Intra Cerebral Hematoma from fall by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peeu 1 ☐ Yes 2 No 1 TYes 2 □ No certificate Division of Vital 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 548, 1ecT Certification: After 1 Naturel 5 Pending FELL AT HOME or Attandin after death. Director: Aft 1 Yes Apr 29 99 unknown 2 Accident 3 Suicide investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 707 MAIDEN CHOICE LAME APT. 9290 CAPONSYLLE, ND 2008 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide CATONSYLLE, MD 2000 24 hours a 29a. Certitier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. Medical completely To the I 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifique 29c. License number en, 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) GENS E ST. BALLO, MD 21201 DAUG South

AH 10

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

1999



Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Michael R. Stowe

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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1999

04

3. Time of Death

2130

2. Date of Death

APRIL.

Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	r Location of Death	4c. County of Death				
	4816 TOPPING	RD.			ROCKVII	LLE	MONTGOMERY				
Funeral Director	5. Social Security Number 6 unknown Usual Residence of Decedent	ınknown 10xm 2□F 38 Y				r If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplat Country Sept. 26, 1961 D.C.					
5 Km	10a. State 10b. County	10c. C	ity, Town or Location	on				10d. tnside City Limits			
death with the Maryland ms 23s or 28s-f show Linual be notified at heral Director	Maryland Montgo		1 ☐ Yes 2 HNo								
or 28s-f	10e. Street and Number	110	ckville	Of. Zip Code		10	Da. Citizen of \	What Country?			
A S S											
w 23s muntite	4816 Topping Roa	12. Was Decedent Ever in U				Specify Ves or No-	U.S.A. 14. Race - American Indian,				
at. or the Examina by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?			ban, Mexican, Puè o <i>Specify</i> :	Specify Yes or No- irto Rican, etc.)	Blad	ack, White, etc. ity: white			
ted fred	15. Decedent's	Education	16a. Decedent	s Usual Occ	upation	advisa	16b. Kind of B	usiness/Industry			
ed within 72 ho yglere. we then "naturit, the Medical. It, the Medical.	(Specify only highest g Elementary/Secondary (0-12) 10	College (1-4or 5+)	Cashie	VOT use reti	e during most of w red)		Gas Sta	ation			
exec a	17. Father's Name (First, Middle, La				18. Mother's Na		ddle, Maiden Surname)				
ahould be and Mental america ov america eve	John J. Stowe				Alma M	ae Schofi					
and N and N is man	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing A	ddress (Stre	et and Number or F	Rural Route Number,	City or Town,	Stata, Zip Coda)			
1 and 2 Health a em 27 la Wher tra	Vicki Collins/s:	ster	9909 Bo	ise Ro	ad. Laur	e1. MD 20	1, MD 20708				
Pages 1 a ant of He mt: If Nem ry or othe	Vicki Collins/sister 9909 Boise Road, Laure1, MD 20708 20a. Method of Disposition 1□ Buriat 2□ Cremation 3□ Removat from State 4□ Donation 5 ②Other (Specify) in state										
Physician /Medical Examiner	Immediate Cause (Final disease or condition	implications that caused the dealy one cause on aach line.	Ba1	timore e mode of d	ying, such as cardi	201 ac or respiratory arre	est,	Approximate Infarvat Between Onset and Death			
executed named tel-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or insury	b	or as a consequen		ŀ	read					
nding physus as the	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	oe of):							
ed by th detachs											
The law requires to the state of the state o				ř.		24a. Was ar perform Limit	ned7	24b. Were autopsy findings available prior to completion of cause of death?			
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Physician: The Inia certificate rail director, pa	25. Was case referred to medical examiner?					eath (Check only on	9)				
To To	1 💢 Yes 2 🗆 No						nce 6 🗆 Oth	ner (Specify)			
Alle fune fune form	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigat		28b. Time of Injury J	28c. In W	uryat ork7 ∐Yes 2,DaNo	28d. Describe ho	shot	SCIA			
or Attendent She deat In by the srtifica	4 Homicide determine	32 Suicide 6 L. J Guide Not be 28e. Place of Injury - At home, farm, street, factory, office					281. Location (Street and Number or Rural Route Number, City or Town, State) 4816 Topping Read				

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) APRIL 05, 1999

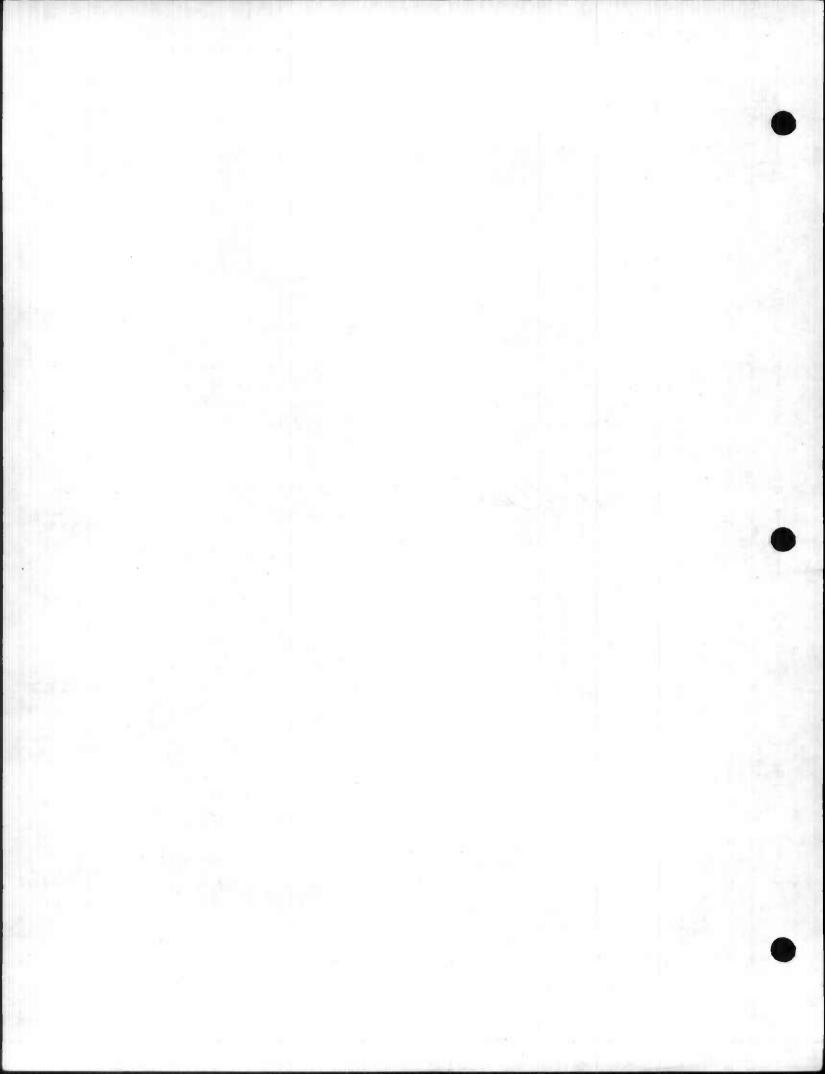
and address of person who completed cause of death (tterp 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 29a. Certifier

phrn adentz 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 1999

29c. License number O.C.M.E



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY 11:13 P.M HAZEL M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALTIMORE SINAL HOSPITAL OF BALTIMORE If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Data of Birth (Month, Day, **Funeral** -28-2962 1 M 2 F Months Days Hours Director Usual Rasidanca of Decedent 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits ma N. A. Balto 1 Yes 2 No Director 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b 5-W 4.5. 401 Nems 23s 21218 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married Black Maryland 21215-0020 'natural, or 1 Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Pages 1 and 2 should be filed within I next of Health and Mental Hygiene. ant. If Ilam 27 is marked other than " J. H. Universel College (1-4or 5+) Elamantacy/Secondary (0-12) Supervior Ellisary important: if hen 27 is marked oths any injury or other traumatic event once. 17. Fsthar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NARPIEL ASAB 19e. Informant's Name/Ralationship (Type, Print) LULA Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) leo reld Rd 10 14BB, LOCKS 20b. Place of Disposition (Nama o 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Ramovel from State artulus artulino 19/9 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licenses 23a. Peri 1. Entar/tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical SEPSIS 4 days Examiner Due to (or as a consequence of): Examiner DBSTRUCTION GASTEO INTESTINAL Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disaese or injury that initiated events resulting in death) Last Dua to (or as a consequence of): and Box 68760 physician Physician/Medicai Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by OBSTRUCTIVE PULMONARY 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed HYPERTENSION ANEMIA 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was casa referred to medical examinar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To 27. Mangar of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of After 5 Panding Natural efter deeth.

Director: Aft
d in by the fur 1 Yes 2 No invastigation 2 Accidant 6 Could not be datermined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Completely filled Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian Medicai 29b. Signatura and little of contifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

ALEDICAL DOCTOR

32. Registrar's Sonature

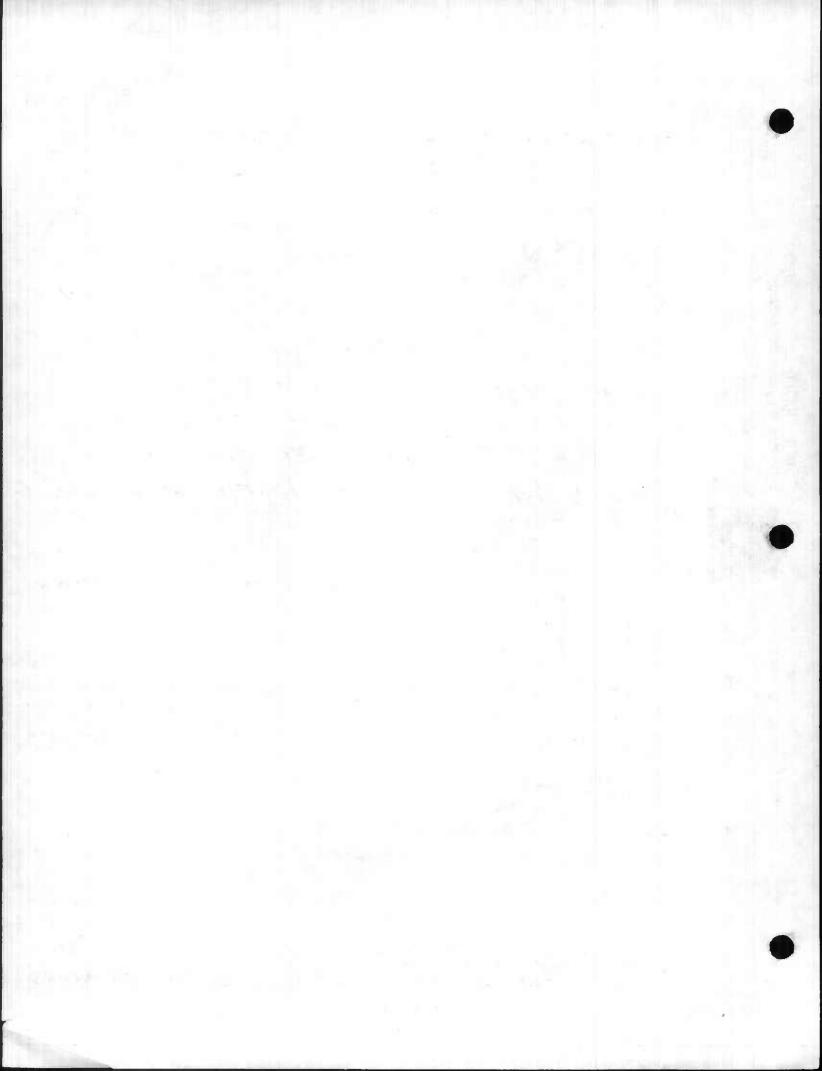
one end addrass of person who completed cause of death (ftem 23a) (Type, Print)

COOLEY

31. Data filed (Month, Day, Year)

P12313

MEDICAL DOCTOR, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				rtificate				lental Hy	Reg. No.		5748					
	Physic /Medi		KICHAND A. ICHNEK									2. Dete of Deeth Month, Dey		/ Yeer / 999	3. Time of Deeth 0724	
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	Funeral Director		5. Social Security Number 214-44-3358		Gex I∏M 2□F	7. Age (In yrs. lest birthday, 51 Yrs.		Months Deys		If Under 24 H Hours Mi		8. Date of Bir (Month, De	y, Year)	9. Birthp	Birthplece (State or Foreign Country) MD .	
	a yland show		Usuel Residence of Deceder 10a. State 10b. Co			10c. Ci	ty, Town or Lo	ocation						1	0d. Inside City Limits	
	or 28e for	ctor	MD. N	/A		В	ALTIMO	RE							1 □XYes 2 □ No	
	h with th	Funeral Director	10e. Street end Number 721 N. COLLII	IGTO	N AVE.		10f. Zip Code 21205			1			10g. Citizen of Whet Country? USA			
729	filed within 72 hours after death with the Ma Hygiene.	þ	11. Maritel Status 1 Never Merried 2		Armed F	2 ∄No ive		13. Was Decedent of If Yes, specify C		of Hispenic Origin? (Specify Y Cuben, Mexican, Puerto Ricen No Specify:				Reca - American Indien, Bleck, White, etc.		
Manylando29245-0020	s within 72 ho liene.	Completed	(Specify only hi	(Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+)		(Give	dent's Usuei O kind of work d DO NOT use re ORER	suel Occupetion work done during most of working Tuse retired)			ing	16b. Kind of Bus		Siness/Industry		
Church	0 - 30 -	To Be Co	17. Fether's Name (First, Mid RICHARD JOH)							18. Mother's Name (First, Middle, Meiden Sumeme) HAZEL CHASE						
Many	1 and 2 sho Health end N em 27 is ma wither trauma		19e. Informent's Name/Relat SHAVON GOODS			HTER)	19b. Meiiii 240	ng Address (Si S. DALI	treet e	CT.	BAL.	rimore,	er, City or Town MARYLA	n, Stete, Zip ND 21	Code) 231	
mome	or of H		1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State				lece of Disposition (Neme of emetery, cremetory or other plece) ZION CEMETERY					Dete 20c. Locetion - 5-17-99 BALTIMO			City or Town, Stete ORE, MARYLAND	
- 12	permi. Pa Deperment important: eny injury		21. Signeture of Funerel Servica Licansee 22. Name end Address of Fecility								E II.	PHILLIPS FUNERAL HOME, P.A. E ST. BALTIMORE, MARYLAND 2121				
			23a. Part1. Enter the diseese shock, or heert failure.	, or comp List only	plications thet one cause on	caused the deet eech line.	h. Do not ent	er the mode of	f dying	g, such es	cerdiac	or respiretory e	rrest,		Approximete Interval Between	
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90,	cete be executed physician end the buriel-transit															
Box 68760,	eath certificete t attending physic for use es the t	v/Medical	thet initieted events resulting in death) Last	uence of):							-14					
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Records,	e law requires has been sign ge 2 should be												24e. Wes perfo	an autopsy med?	COL	ore autopsy findings ellable prior to expletion of cause deeth?
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Vital	Physician: The this certificate ral director, par	o Be	25. Wes case referred to med examiner?	-	Hospital:	Anation 20	FD/Outpation	2000	Othe	r.		(Check only o		10		
Division of Hospital or Attending Physics	ling After fune	-	27. Menner of Deeth 1 Driaturel 5 Pending (Month, Day Year) 28b. Time of Injury		28c.	Injury Work 1 🗆 Y			Home 5 Residence 8 Other (Specify) 28d. Describe how Injury occurred							
	tal or Attend is effer death ii Director: ed in by the		3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide det	ild not be ermined	286. PIGCS	of Injury - At ho ing, etc. (Specif	ome, ferm, str	eet, fectory, off	fice			28f. Location (S City or Tox		ber or Rura	l Route Number,	
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- 588964 - Jennifer Moryl.

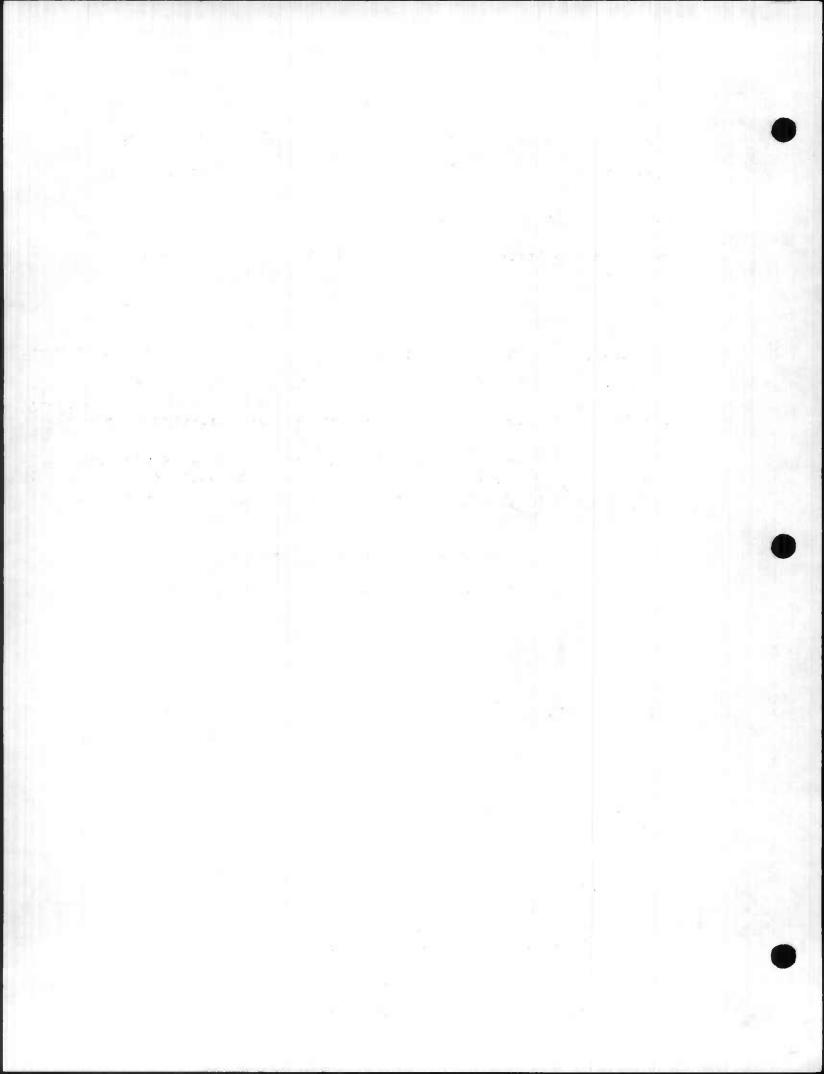
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Bon ARA TUCKER 1999 MAY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HOSPITAL SECOURS NA 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1□ M 2 F 88 240-01-3637 Director NC Usual Residence of Decedent 10a State 10c City Town or Location 10b County 10d. Inside City Limits ns 23a or 28a-f st must be notified 1∏Yes 2□No MD Director NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1908 N. Wolfe Street 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: by **¾** Widowed 4 □ Divorced "natural", Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. ther than Elementary/Secondary (0-12) College (1-4or 5+) in & out of home 6th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 ahould be (in ment of Health and Mental Heants III) ant: If Item 27 is marked oth jury or other traumetic event Be Charlie Allen Ella Allen 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 1 3 19a. Informant's Name/Relationship (Type, Print) 1908 N. Wolfe Street Baltimore, Maryland Geraldine Waters 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Kings Mem. PK. Cem. 05-15-99 Randallstown, MD re of Funeral Service License 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CARDIAC ARRHYTHMIA disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE -tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue certificate be exec physician at s the burial-t P.O. Box 68760. Physician/Medical the Due to (or as a consequence of) 98 esn for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown MALNUTRITION Records. PV 24b. Were autopsy findings available prior to 24e. Wes en eutopsy Completed performed? completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **4** ☐ Homicide Hospital 24 hours 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 030272 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) THOMAS MILLER BON SECOURS HOSPITAL BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 4 1999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: #10G PER F.H. G771 5-14-99 WR dent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician las /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor M Under 24 Hrs. 8. Date 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1□M 2XF Months Hours Jam Yrs. None Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frama 23a or 28a-f ahov traumatic event, tre Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director mor arvland 10e. Stre et and Number 10f. Zip Code 10g. Citizen of What Country? death with d JAMAICA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Maritel Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) ge (1-4or 5+) Ke omema om pemit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumarpe) Be 19b. Meiling Address (Street and Number or Rurat Route Number 50 C prom 20b. Placa of Disposition (Name of company, crematory or other place) 20a. Method of Disposition 1 Burlel 2 Cremetion 3 □Removal from State 410n 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fagiting dure of Funeral Service License eral Joseph 2222 V W. North . 2/2 ter the mease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest heart them. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Less Than Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the Due to (or as a consequence of): signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No Be Completed by 24a. Wes an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death? 2 10 No 1 Yes 210 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending Investigation 1 Yes 2 No the 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ SuicIde 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completaly (Check only one) e di 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 66 30 14

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DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

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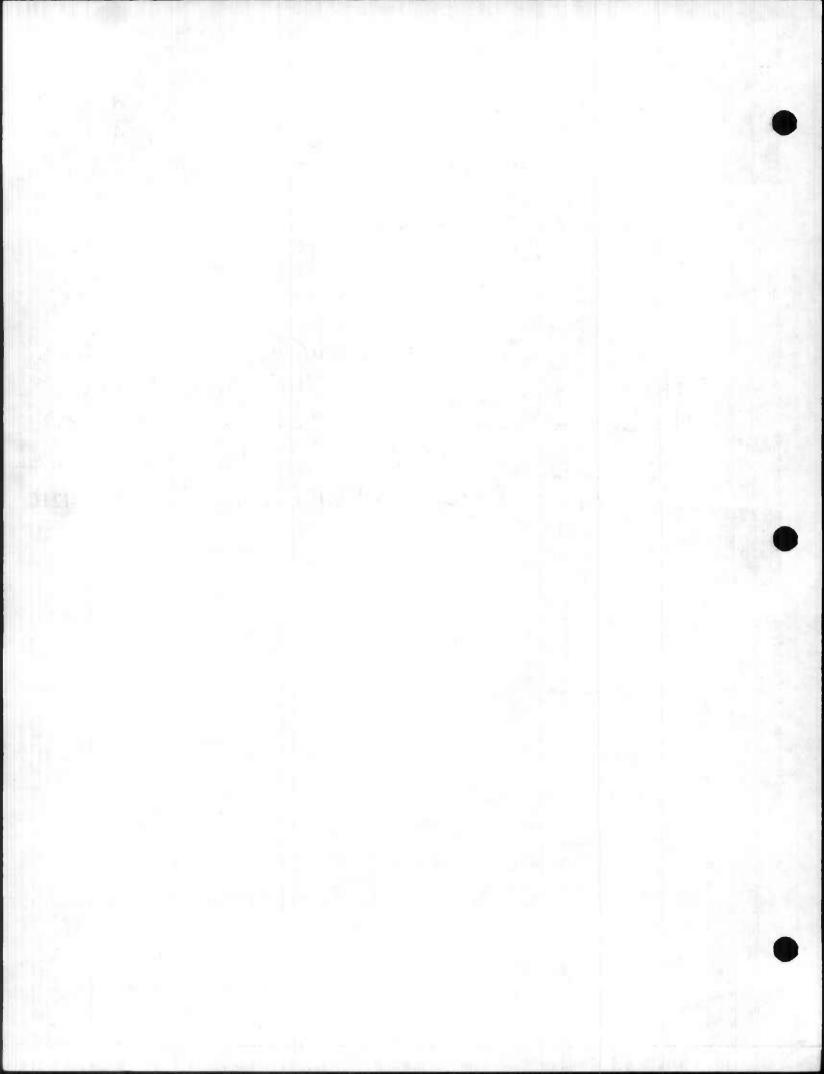
TRIPUP

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30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) SIREESH 5601 LOCK ROUND BLUE, Baltimore;

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Weber 1:53 AM Mildred 1999 13 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Center Bayriew Medical Baltimore Hopkins If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (in yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Yrs 214-12-1126 Jan. 04, 1920 Maryland Director Usuel Residence of Decedent death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Directo Baltimore Maryland n/a/ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 8012 Bank Street 21224 Funerai Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "naturel", or itel any highry or other traumatic avent, the Medical Examinations one. 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 1 Yes 25 No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 8 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward J. Lurz Marie Sperzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8012 Bank Street, Baltimore, Maryland 21224 Wilmer J. Weber, Jr. (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/99 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name end Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final Dreum ani disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner requires that the deeth certificate be executed physician and s the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai attending pl 23b. Did tobacco use contribute to the ceuse of deeth? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evellable prior to completion of ceuse of death? 24a. Was an autopsy Completed aw s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was cese referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 5 Pending Investigation 1 Natural 1 Yes 2 No daath. 2 Accident ofter daat Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital or J within 24 hours efter To the Funeral Dire completely filled in b 1 (Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

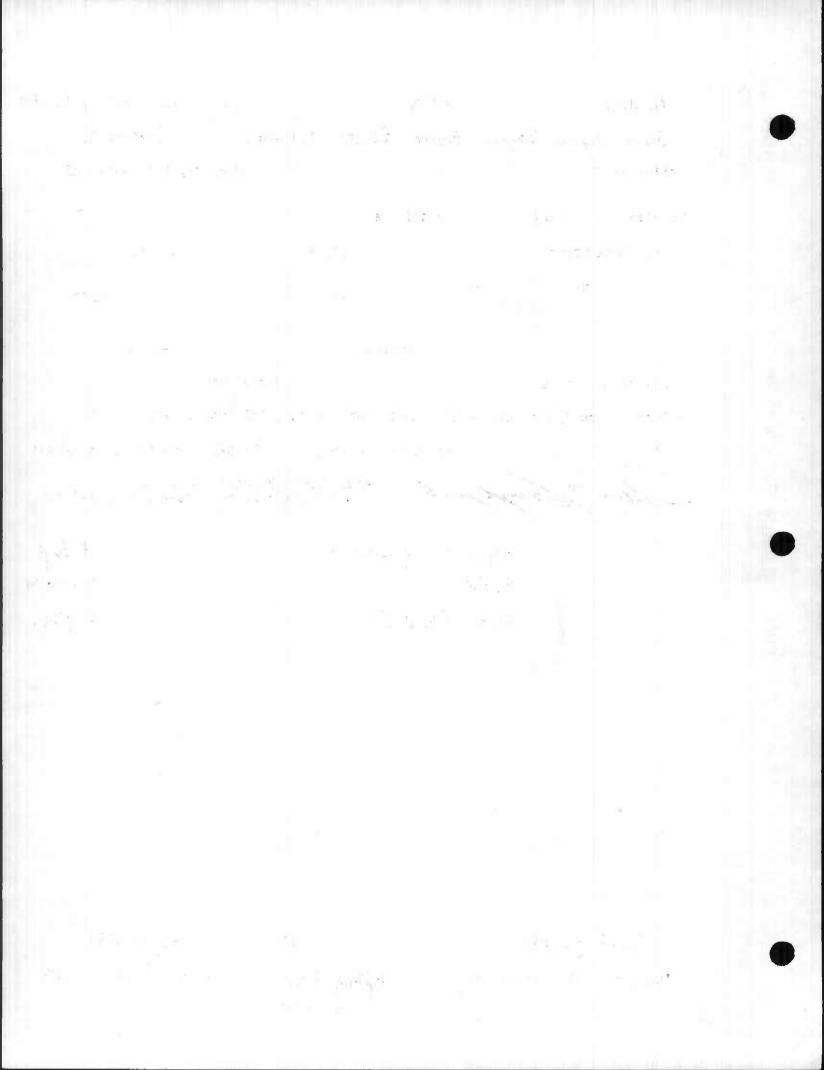
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number yn, MD May 13, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins, Hospital, Baltimore, Maryland

State Registrar **DHMH 16 Rev 6/95**

MD, Tower 110,

MAY 1 4 1999 Registrals Signature

Johns



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Date of Death 3. Time of Death 2:40 P.M. John William Walter May 12, 1999 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare at Hammonds Lane Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex 1∆ M 2□ F 8. Deta of Birth (Month, Day, Year) Aug. 30, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days Hours Yrs. 218-07-2021 1914 Maryland Usual Rasidance of Dacedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 X No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7553 Teaque Road 21076 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: 14. Rece - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Nevar Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamentary/Secondery (0-12) 12th College (1-4or 5+) President Banker 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) John William Walter, I. Florence Meffner 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7553 Teague Road Hanover, Maryland 21076 Lore E. Bauer (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Crametion 3 Removal from Stata Glen Haven Memorial Park 5/14/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Euneral Service Licensee Kevin E. Ecker MCCUITY-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset end Deeth Immediata Causa (Final disaasa or condition resulting in deeth) Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last orongy Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to complation of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 LNG 1 Yas 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Other: Other: 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 ONaturat 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 \ Homicida 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated. 2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier

Examine physician and the bunal-trensit The law requires that the death certificate be executed Box 68760. Physician/Medical Records, P.O. signed to by Completed Division of Vital Be edical Certification; To this After or Attanding after death.

Director: Aft
d in by the fur A 24 hour. the Funeral Directory hours after

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Heelth and Mental Hyglene.
Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examines page.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

death

To the Hosp within 24 hor To the Fune completely fi

DHMH 16 Rev 6/95

Hospital

State Registrar

1999

31. Data filed (Month, Day, Year)

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29b. Signature end the of certifier

30. Nama and addrass of pr

32. Registrar's Signature

carsa of death (Item 23a) (Type, Print)

29c. License number

29d. Date/signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yaar Physician 12, May Mary Creighton Walton 1999 10:20 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 321 Gusryan Street Baltimore N/A9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 8. Data of Birth (Month, Day Year) APR 1, 1914 5. Social Security Number if Undar 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 20 F 85 217-20-2821 Director Usual Residence of Decedent the Meryland 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at No Yas 2□No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 321 Gusryan Street 21224 USA Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours efter on ant of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or itea ury or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Unk. Jennie Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny J. Dunn/Granddaughter 4300 Elliot Ave. Titusville, FL 32780 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Pege Department of Important: If any Injury or Metro Crematory, Inc. 05/13/99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) Cremation Foociety of Maryland, Inc. 21. Signature-of Funeral Service Lice my 299 Frederick Rd. Baltimore, MD 21228 regorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or raspiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Pas year /Medical tmmediate Cause (Finat disease or condition resulting in death) Examiner Examiner physicien and the buriel-trensit death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as a consequence of): 80 esn for ed by the a 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Pert !. 1 Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? hes page 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Menger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 1 Natural 5 Pending 1 Yes 2 No r death. Investigation 2 Accidant efter death Director: 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) Placa of Injury - Af home, farm, streef, factory, office building, etc. (Specify) 3 4 Homicide filled in Hospital 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred et the time, dete and ptaca, and due to the cause(s) and manner stated. (Check only onel To the within 2 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

Baltimore, Maryland 21215-0020

Box 68760.

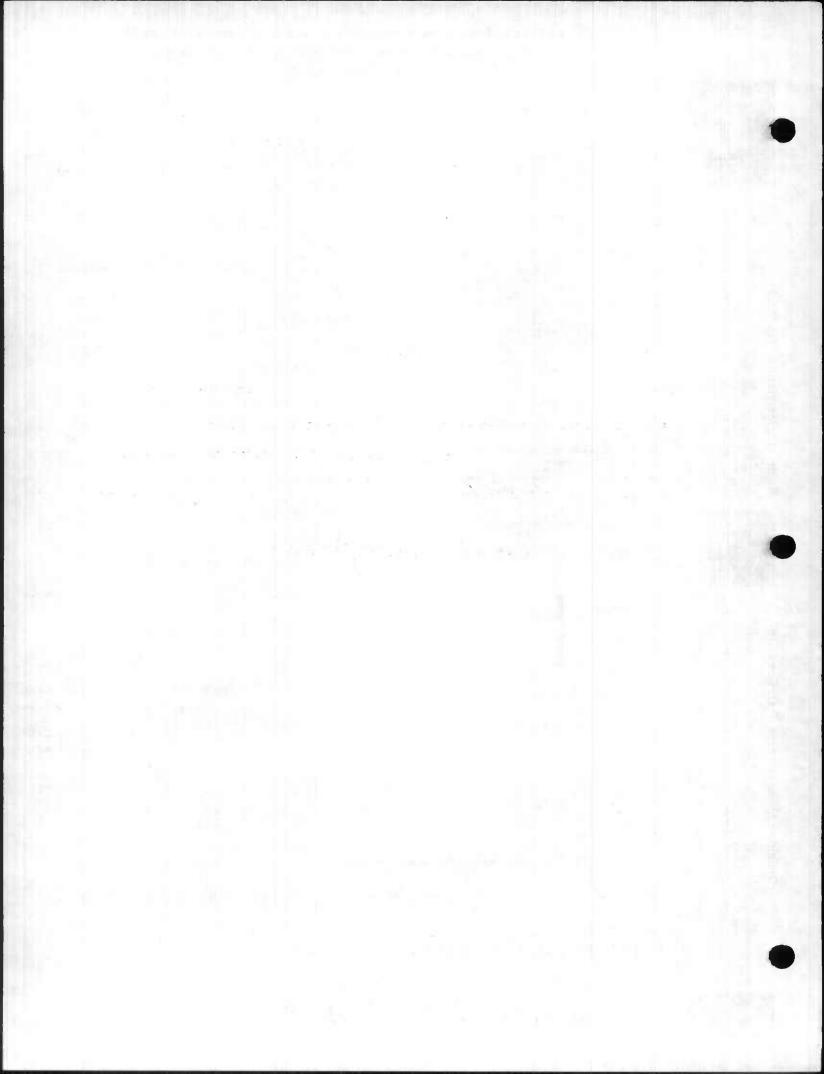
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Division of Vital Records,

Registrar

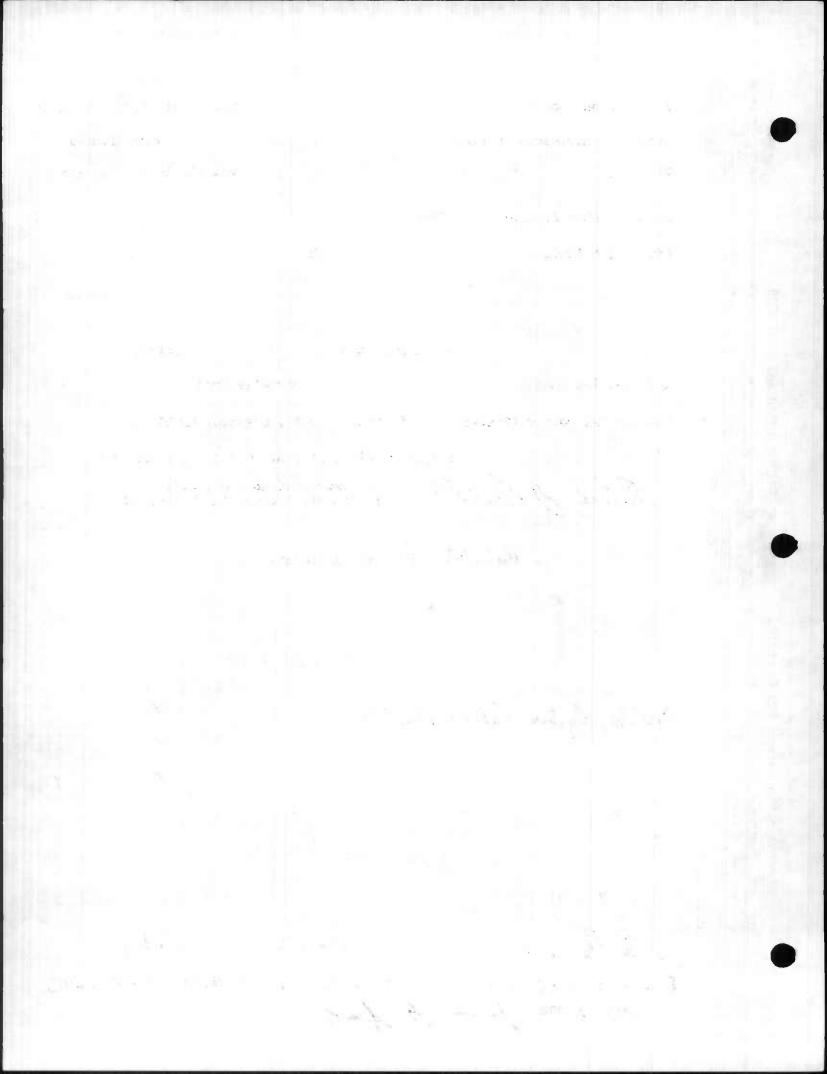
31. Date filed (Month, Day, Year, 32. Registral signature

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Ptht)



State of Maryland / Department of Health and Mental Hygiene

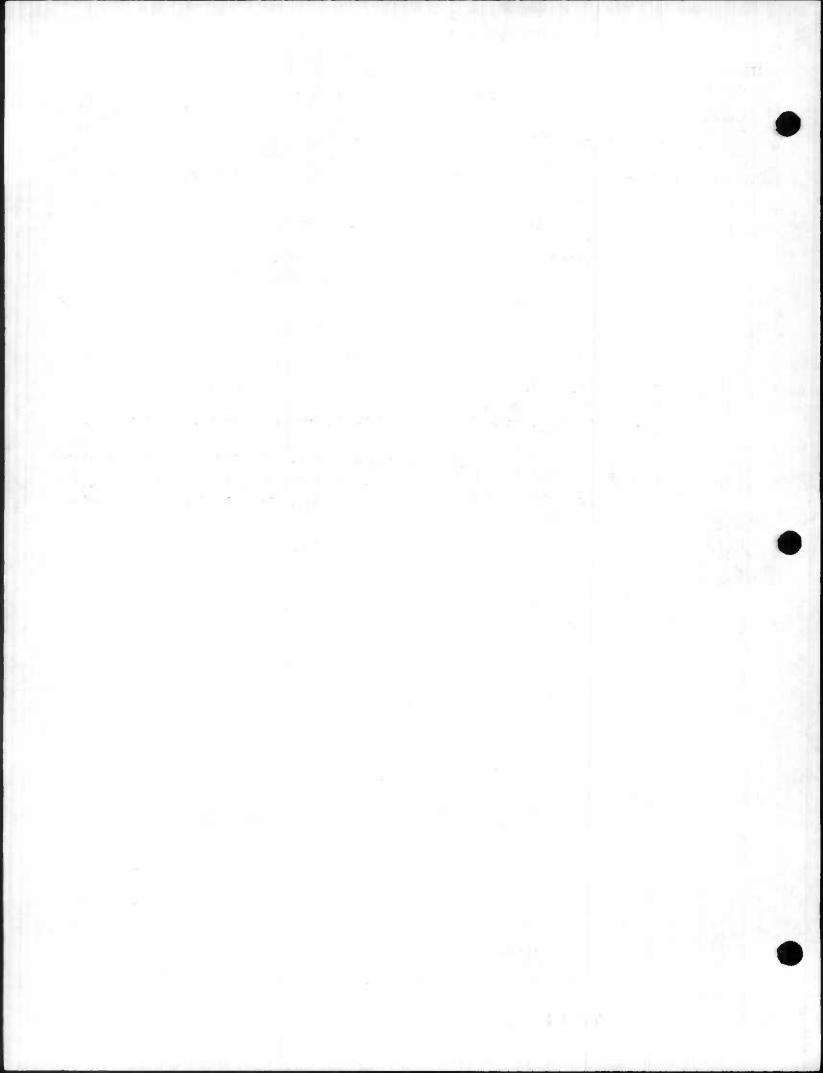
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Dhualalan		ame (First, Middle,	Last)					2. Date of Month		Day	Year	3. Time of Death	
Physician /Medical	SHELLY	Diane We	elch					May			999	8:10 am	
Examiner	4 - Facility Man	e (If not institution, s	give street and num	iber)			4b. City, Town	, or Location of De	eth	4c. County	of Deeth		
		on Convale	escent Ce	nter			Crofto	n		Anne	Aru	nde1	
Funeral Director	5. Social Securit		. Sex 1 □ M 2	7. Age (in yrs. i 47	last birthday) Yrs.	Months Days		Hrs. 8. Date of (Month, Aug.	Birth Day, Yes	1951	9. Birthp Court Vir	elace (State or Foreign etry) ginia	
2	Usual Residence	_											
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or 28efs be notified	10e. Street and					10f. Zip Code			10g.	Citizen of V	Vhat Cour	itry?	
th will 23s o 25s o 25b o	485 Ki	ng Malcol	Lm			211	13			USA	1		
Maryland 212.15-0020 d.2 should be filed within 72 hours after death with the Marylan th and Merital Hygiene. T is marked other than "natural", or items 23s or 23s-f show traumatic event, the Medical Examiner must be notified at To Re Completed by Euneral Director.	3 ☐ Widowe	ls larried 2⊡ Married d 4 X Divorced	Armed For	2 X No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 No		n? (Specify Yes or Puerto Rican, etc.)	No-		k, White,	en Indian, etc. hite	
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I Z1Z15-0 od within 72 ho vygene. Ner than "netur it, the Medical.	Elementary/S	econdary (0-12)	College (1-	4or 5+)		DO NOT use retir	ed)		N	urain	~		
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VIBRO	Roy St	erling A	•					ella Woo					
iryldi ihould bi id Menta markad marke e		Name/Relationship			19b. Maili	ng Address (Stree		or Rural Route Nu		tv or Town.	State, Zio	Code)	
Ma Dd2; Dd2; Bbar 27 is		e Mae Bet		ter)				Odenton,					
other to	20a. Method of					osition (Name of matory or other pl		Dete		Location -		own, State	
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Departimpor Impor Impor	21. Signature of	ateur Service Lie	A Um	1/1	2		y Funer	al Home, nue, Ann			m 21	401	
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e dea the et hed fo	Pert II. Other sig	nificant conditions	contributing to de	ath but not resu	uiting in the u	inderlying ceuse g	given In Part I.	23b. I	Did tobac	co use co	ntribute t	o the cause of death	
s that the and by the deteche	Diale	tu, Lys	time Ly	hw En	thema	Tosu			Yes	2 00NO	3 □ Pro	bably 4 ☐ Unknow	
The law requires that the death certi- sele has been signed by the ettending page 2 should be deteched for use e		, 0	,	V				24a. V	Vas an au erformed	utopsy 1?	av	ere autopsy findings vallable prior to empletion of cause death?	
The ta								1	☐ Yes	20 No	1.0	Yes 2 No	
Or Vital P Physician: The this certificete ral director, peg		eferred to medicel					26. Place o	of Death (Check or	nly one)	-1	-		
hysici nis ce il direc	1 Yes 2	No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA	other: 458 Nurs	ing Home 5 F	lesidence	6 □Oth	er (Speci	(y)	
DIVISION O bal or Attending Ph rs efter death. al Director: After th led in by the funeral Certification: **		5 Pending investiga	tion	f Injury h, Dey Year)	28b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Descr	ibe how l	njury occur	red		
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To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be 6		Certifying 2 Medical Ex	Physician: To the la aminer: On the ba and mann	sie of examinet	wledge, deat tion end/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to occurred at the til	the cause me, date	e(s) and ma and place,	anner es s and due t	steted. the cause(s)	
To the comp	The second secon	ndettle organtifier				29c. Lice	nse number		29d.	Date signe	d (Month,	Day, Year)	
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AL IN A	30. Name and a	ddress of person wi	,	e of death (Item	23a) (Type,					1			
Cana	21 Date filed (I	EET SU Month, Day, Year)	VGH 510) MU /		HNHPOL	LLS RI	040 #	106	ODE	NTO	N 21113	
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his certifi il director	25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 DOA Othan	26. Place of Deeth (Check only 4 □ Nursing Home 5 ☑ Res		ifu)		
五面 二	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		o. Time of 28c. Injury Work?	T	how injury occurred	<i>y</i>		
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To the Comp	29b. Signeture end title of certifiar	Solve	29c. License	143489	29d. Date signed (Month,	Day, Year)		
	30. Neme and eddress of person who co Brian Bohner MD	ompleted cause of death (Item 23e 1669 North Cha:		Baltimore, M	Maryland 212	204		

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DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Deeth Des Month Yea **Physician** Dante' D. Williams May 1999 23:10 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Yaer If Under 24 Hrs. Birthplace (State or Foreign Country)

Md **Funeral** Montha Days Hours 10XM 20 F 215-88-1685 Director Usuel Residence of Deceden Marviand 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits NEXYes 2□ No Director Md NA 258-1 Baltimore 96 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 3720 Marmon Avenue 238 21207 Funeral 12. Wes Decedent Ever in U,S. Armed Forcea? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Bleck, White, etc. 72 hours after 1 Never Merried 2 Married ò 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Unk Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) 8 Known as 1 and 2 should be Health and Mental Junior Wallace Dorothy Epperson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 any Injury or other to Stephany Williams - Wife 3720 Marmon Avenue Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Pages ō ty∑XBurial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 5-14-99 Baltimore, Md Voshell Memorial 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility March F/H West Ula 4300 Wabash Avenue Warn Baltimore, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical tmmediate Cause (Final Cardiopulmonary Arrest diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Advanced AIDS The law requires that the death certificate be asscuted Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 987 signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, by 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Wea an autopsy parformed? page 2 a has 1 ☐ Yes 2 12 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai Attending Physician: director, 25. Wes case referred to medical example? B 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea 2 No Certification: To 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA this 27. Manger of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? After 1 Neturel 5 Pending 24 hours after death. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homicide 6 filled in Hospital 29a, Certifie 🖫 Certifying Physician: Το the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. Medical iner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) entitlement steted. **#** ☐ Medical Ex within 2 eg. 29d. Date signed (Month, Day, Year)

High

State Registrar

DHMH 16 Rev 6/95

1999

30. Neme and address of person

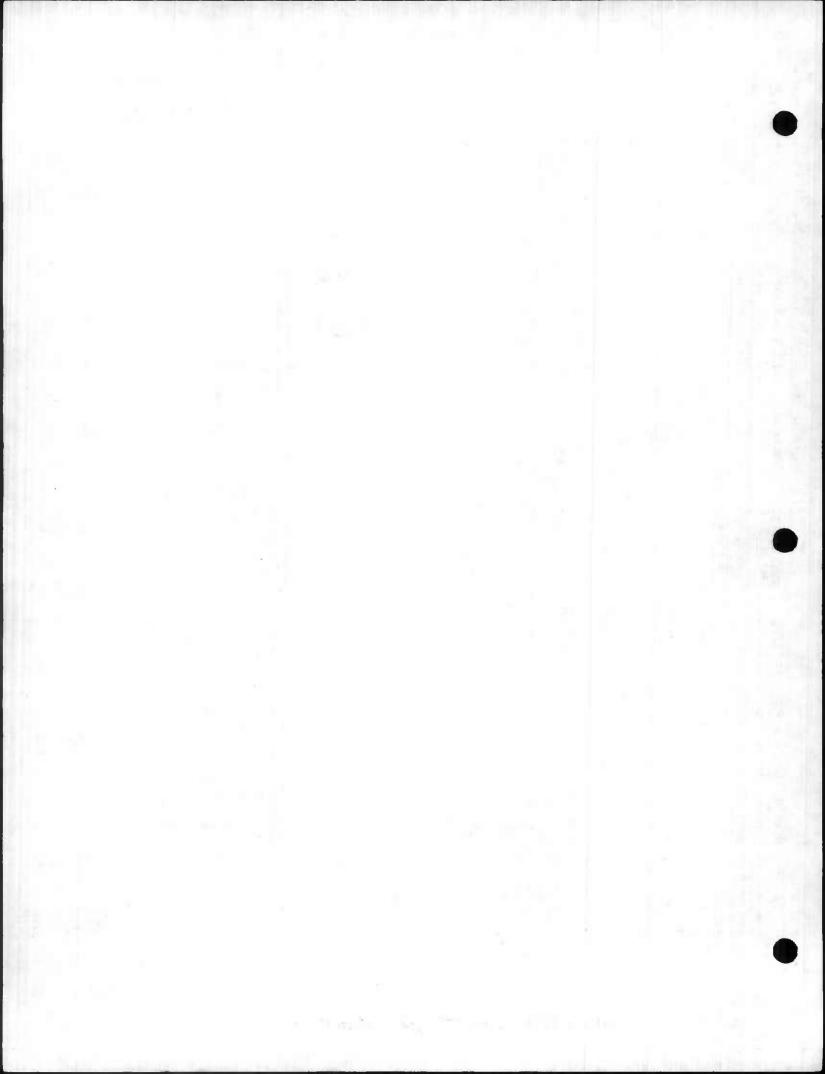
31. Date filed (Month, Day, Year)



pleted cause of death (Item 23a) (Type, Print)

2401 W. Belvedere Ane Balto, and

MID:



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Young Geneva 1999 12:40 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Regional Hospital Prince George's Laurel Laurel If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5-13-10 Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthday) **Funeral** Montha 1□M 20 F S.C. 216-26-7937 88 Director Usual Rasidance of Decedent 10a Stata 10c. City, Town or Location x 28a-f ahow 10h County 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Directo HOWARD **JESSUP** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 8760 MARY LANE 20794 USA Pages 1 end 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.
The Tris marked other than "natural", or items 23, mit; if ken 27 is marked other than "natural", or items 23, my or other traumatic avent, the Medical Estation mail. Funerai 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Never Marriad 2 Married 1 Yas 2 No Specify: Specify: BLACK by 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantery/Secondery (0-12) College (1-4or 5+) PRIVATE DUTY NURSE HEALTH CARE 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema /First, Middla, Meiden Surnama) Be JOHN HENRY DEAN ELDORA TATE 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) GENEVA V. JOYNER (DAUGHTER) 8760 MARY LANE JESSUP, MD. 20794 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Page Department of Important: If any injury or once. MD. NATIONAL MEM. PARK 5-17-99 LAUREL, MARYLAND 4 □ Donation 5 □ Othar (Specify) 22. Nama and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Funaral Sarvica Licensaa CFSP 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 cta erecta 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Daath **Physician** MYOCARDIAL INFARCTION /Medical Immediata Ceuse (Finel disaasa or condition rasulting in daath) Examine Examiner physician end s the burief-transit Sequantially list conditions, if any, leading to immediata causa. Enter Undarlying Cause (Diseesa or Injury that initieted events resulting in deeth) Last Physician/Medicai Dua to (or as e consequance of) for use as Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I 23b. Did tobacco use contributs to the causs of death? signed by the 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown INSULIN DETENDENT PLABETED MELLITUS, 2 24b. Wara autopsy findings available prior to complation of causa of daeth? Completed HIP, HYPERTENSIMU 24a. Was an autopsy i certificate has l 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarrad to medical axaminar? 26. Pleca of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospital: Certification: To 1 Yas 2 No 1 MInpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Manper of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After 1 Natural 5 Panding s after death. 1 Yes 2 🗆 No Investigation 2 Accidant 3 Suicida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify) filled in by 4 Homicida To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

Medical Examiner: On tha basis of axemination end/or investigetion, in my opinion, daath occurred at the tima, dete and place, and due to tha causa(s) and mannar stated. 29a, Cartifian edicai completely 29b. Signeture 29c. License number 29d. Date signed (Month, Day, Year) e of certific

State Registrar

The law requires that the death certificate be executed

Hospital or Attanding Physician:

Division of Vital Records, P.O. Box 68760.

the Meryland

with

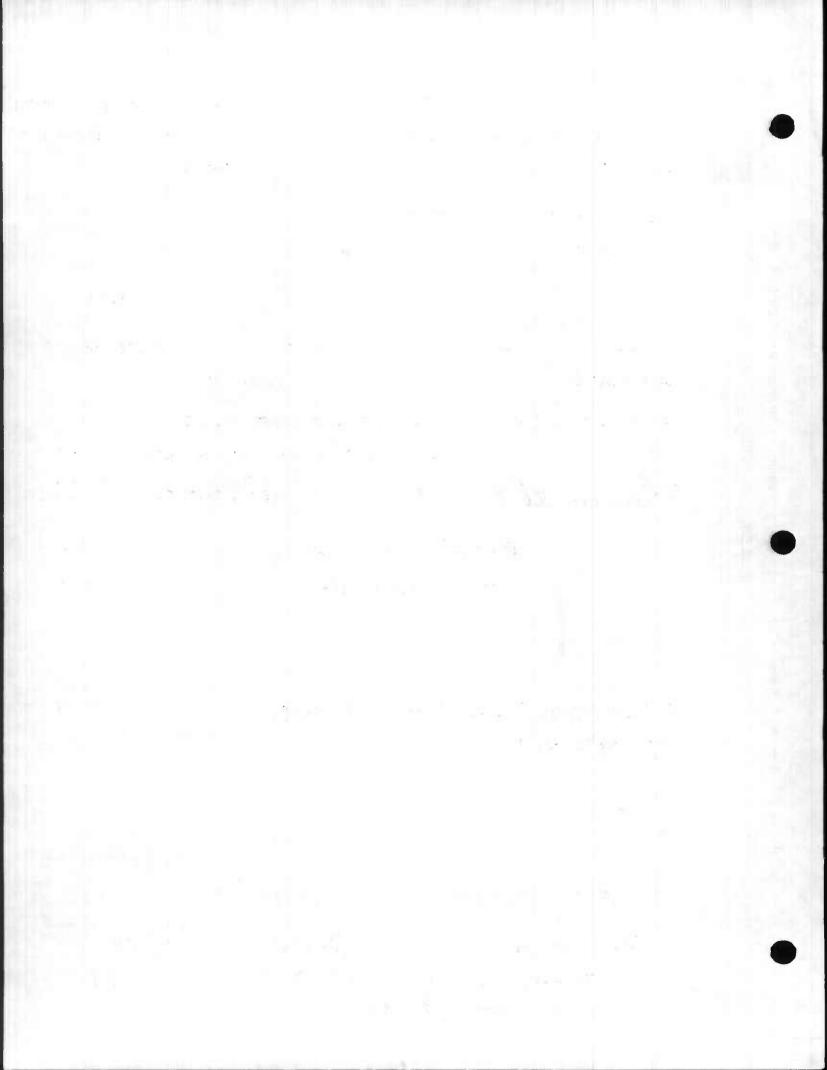
Baltimore, Maryland 21215-0020

31. Data filed (Month, Day, Year) MAY 1 4 1999

30. Nama and Iddrass of person who co

DO 521 PRINCE GEORGE STREET LAVIR ESMALHADO 321 32. Registrar's Signature

DHMH 16 Rev 6/95

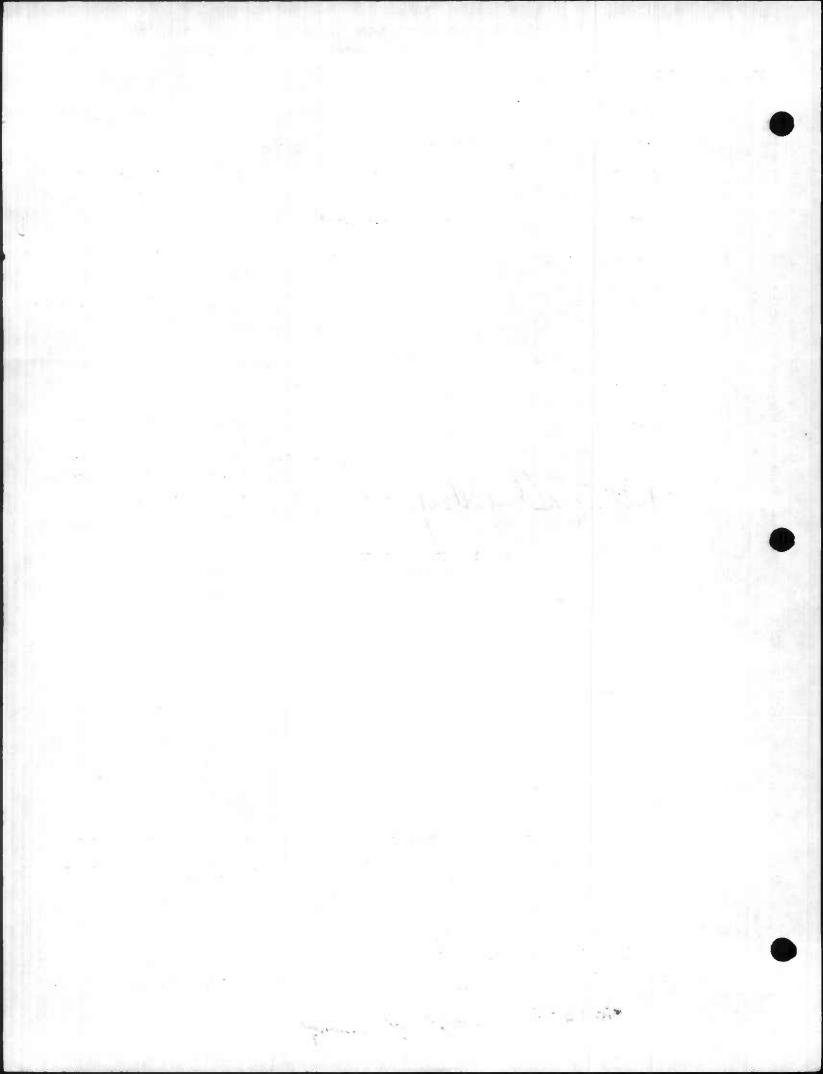


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	State of Maryland	Department of H	ealth and Menta	l Hygiene

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4	M	t. Washington I	Pediatric H	tric Hospital Balti							N/A	
Funeral	5.	Sociel Sacurity Number		Age (În yrs. last birth	Mo	Inder 1 Yaar nths Days	If Under 24 H	in. 8. Data of (Month,	Birth Day, Yes	ar)		ace (State or Foreign
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A NOTE OF		19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number of							mber, Cit	y or Town,	State, Zip	Code)
		Charles Turner		611	Rai	lroad /	Avenue -	- Salist	urv.	MD	2180	1
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OIVISION I or Attending after death. Director: After d in by the fune	80	3 ☐ Suicide 6 ☼ Could no	12-24-				165 212110					Route Number.
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ours surgified filled		a. Certifiar 1 Certifying	Physiology To the he	HOME	double non-			SALISE				
To the Hospital or Attention Within 24 hours after deat To the Funeral Director: completely filled in by the	29		Physician: To the be xaminer: On the besis and mannar	s of axamination and/								
To the Ho within 24 ! To the Fu completel		b. Signature end title of certifiar	and manuar	Statou.		29c. Licens	e number		29d I	Dete signe	d (Month	Day, Year)
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	30.	Nama and addrass of person w	1 2 - (1)	of death (Item 23a) (T		11 Do-	n Chac	+ Dal+	imar	w M-		a 21201
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31. Date fileti (Month, Day, Yee

111 Penn Street, Baltimore, Maryland 21201

op completed cause of death (Item 23a) (Type, Print)

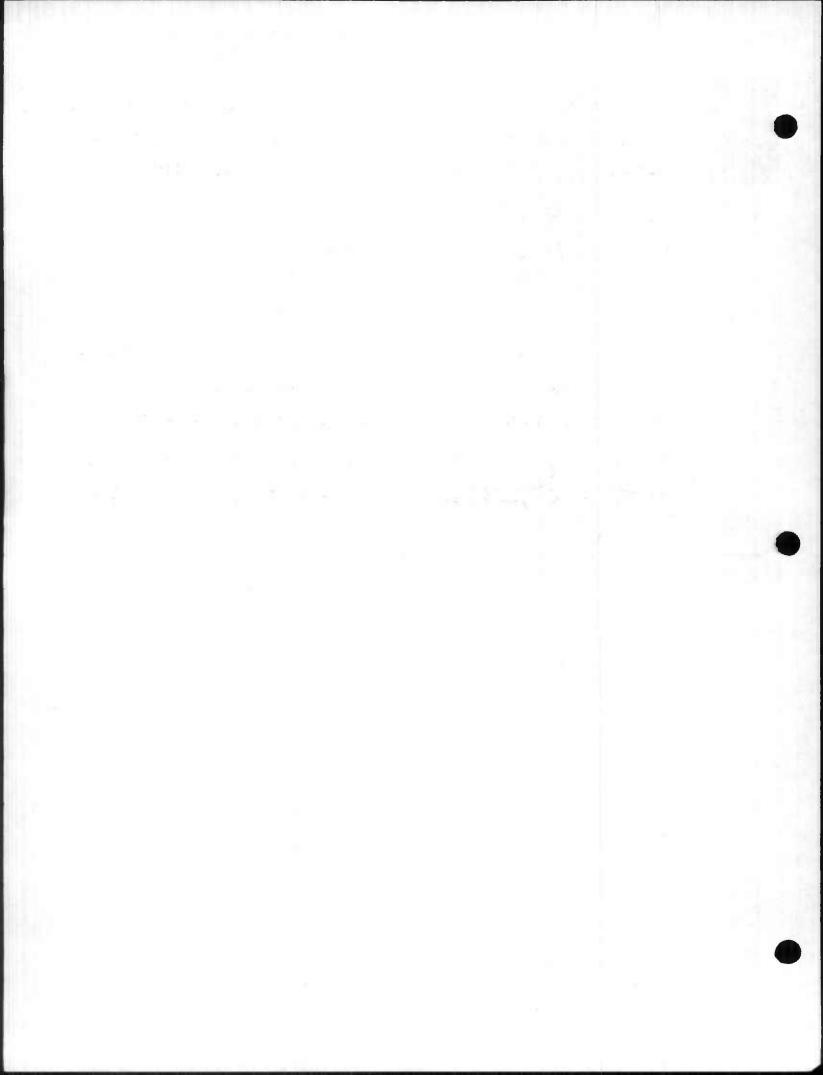
32. Registrer's Signature

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State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day **Physician** Month Charlotte Irene Barnett May 2 5:40 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hagerstown Avalon Manor Health Care Center Washington If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Mooth, Day, Year 916 9. Birthplece (Stete or Foreign Country) Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys 1 ☐ M 2 🖫 F 82 214-12-4885 Yrs. Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Exam set must be notified a space. Washington 1 ☐ Yes 🏖 ☐ No Md. Smithsburg Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12522 Bradbury Ave. 21783 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3. Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk Insurance Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Anna Grace Stoner John W. Ferguson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Roger W. Barnett (Son) 41 Powell Ave. Newport RI 02840-2616 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2X Cremetion 3 Removel from State Smithsburg Crematory May 4,1999 Smithsburg, Md. Donation 5 Other (Specify 21. Signature of Fuheral Service Licel 22. Name end Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Per11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Sudden Cardie Death interior Examiner Due to (or es e consequence of): Physician/Medical Examine Anthus release physician and the burial-transit the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, Due to (or es e consequence of) 80 for use es P.O. signed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed page 2 s 1 Yes 2 No 1 Yes 2 No at or Attending Physician: T s efter death. I Director: After this certificat ed in by the funeral director, p Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ANATUrel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Directon pletely filled in by 29e. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) War 5, (333 D(8019 - (BUTTOMO 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Vasant Datta 334 Mill Street Hagerstown, MD 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State

Registrar

MAY 0 5 1999



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:37 William Irving Dunnell /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Desth 4c. County of Death Examiner WASHINGTON ASSPITAL HAGBRI County noun WASHINGTON Birthplece (State or Foreign Country)
 TOW a 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** ₩ 20 F Months 58 482-42-5823 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Medical Examinar must be notified at 1X Yes 2 No Keedysville Washington Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21756 U.S.A. 24 North Main Street pernit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X)No If Yes, Give Year or Dstes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Msrried 2 ☐ Msrrled 1 Yes 2 No Specify: Specify: White py 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Director of Library Services Private School 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Isabell Johnson Bunnell Jeannette Clausen Wallace 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) Elizabeth A. Bunnell 508 East Broadway, Fairfield, Iowa 20b. Plece of Disposition (Name of cemetery, crematory or other pisce) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2X Cremation 3 ☐ Removel from Stete injury or 4 ☐ Donation 5 ☐ Other (Specify) 05-04-99 Smithsburg, Maryland Smithsburg Crematorium 22. Name end Address of Fecility Andrew K. Coffman Funeral Home, Inc. R. neel. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Md. 21740 Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in desth) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner BU MONIA attending physician and for use as the buriel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 PKRKA LOMIA Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown yd bengis JAUNDICK, ALCOHOLD Division of Vital Records, Completed by 24b. Were sutopsy findings available prior to 24e. Was en sutopsy performed? TOBALLO US completion of cause of death? aw certificate hes 1 ☐ Yes 2 ☐ No funeral director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA within 24 hours efter death. To the Funeral Director: After this 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fsctory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ò **Ecritifying Physicisn: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29s. Certifier Medical (Check only one) the 29b. Signety e end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040622 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

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32. Register's Signature

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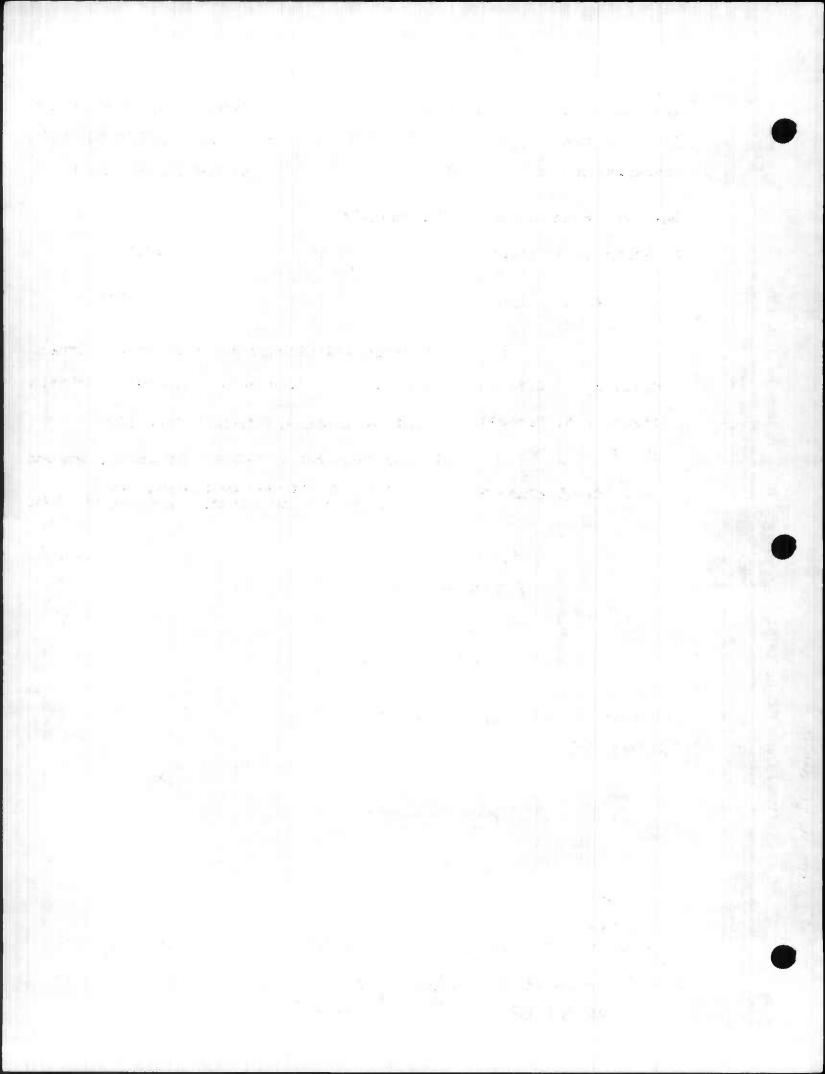
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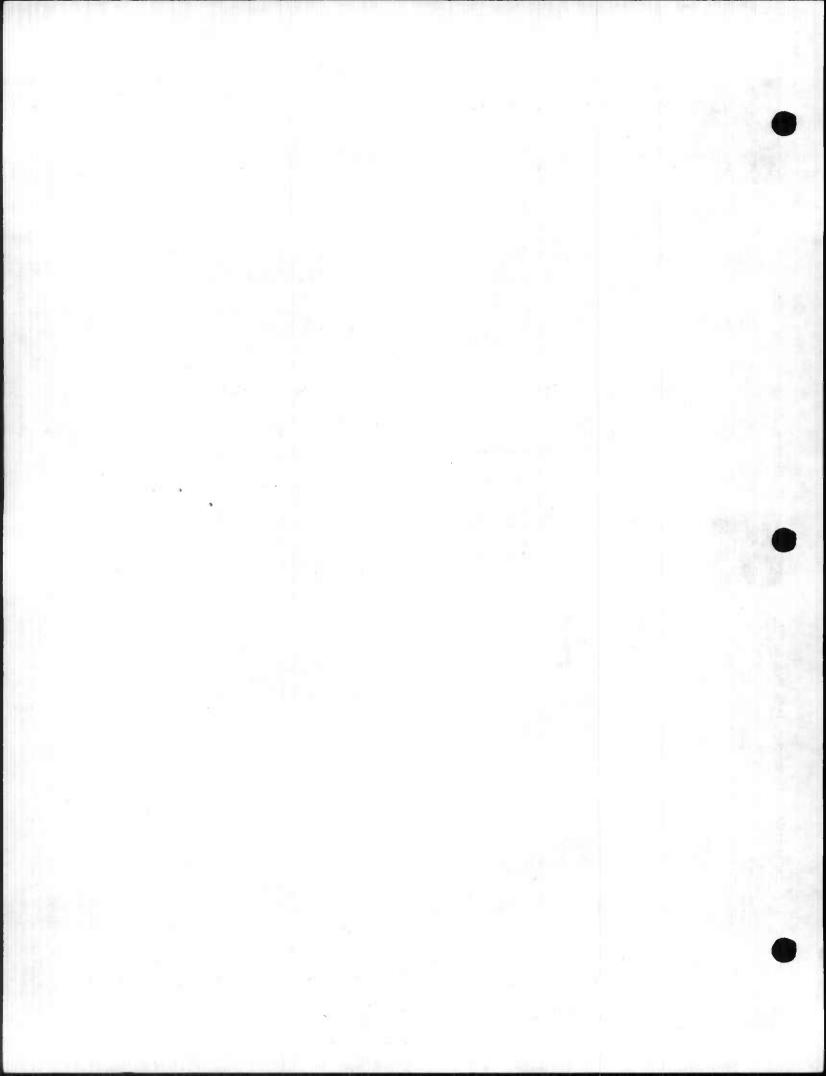
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Burnell, William



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in	I. Decedent's Nema			Tee				2. Dete of De Month	Bath Day	Year 3. T	ima of Death		
al	Paul E11						4b. City, Town, or	April	23, 199 h 4c. County		35 P.M.		
5	1694 Pin 5 Social Security Nu 217-78-9	e Swamp umber 6.	Road	7. Age (In yrs. 42	last birthday) Yrs.	If Under 1 Year Months Days	Barton	s. 8. Data of Bi	rth ay, Year)	Garrett	Stata or Foreign		
-	Usual Rasidence of 10a. Stata	10b. County		10c. Cit	ly, Town or Lo	cation				10d. Ins	ide City Limits		
5	MD	Garre	tt	Ban	cton						Yes 2⊠No		
1	IOs. Street and Num	iber				10f. Zip Code			10g. Citizen of 1	What Country?			
1	1694 Pin	e Swamp	Road			2152	21		USA				
1	11. Meritel Status 1 Nevar Marrie 3 Widowed		12. Wes Dece Armed For 1 Yas If Yes, Giv Year or De	ces? 2 No		Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (pan, Mexican, Pual Specify:	Specify Yes or Norto Rican, atc.)	y Yes or No- zan, atc.) 14. Race - American Indian, Black, White, etc. Specify: White				
		15. Decedent's E fy only highest g		-4or 5+)	(Giva i life. E	O NOT use retire	during most of wo d)	orking	16b. Kind of Business/Industry				
L	12 th				Farme	r/Logger			2				
1	7. Fathar's Nama (i			Con					, Meiden Suman	na)			
	Paul Ell 19a. Informant's Ne			sr.	10h Meilin	a Address /Street			Jean Weimer ral Route Number, City or Town, State, Zip Code)				
	Eleanor			r					arton, MD 21521				
2	20a. Method of Disp	osition		20b. F	Place of Dispos	sition (Neme of setory or other pla		Data					
2		Cremation 3 l 5 ☐ Other (Spec	□Removal trom 5	iale	Ann's		April 27	1999	Avilto	n, MD			
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. B													
rnysiciarymedical Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initieted events rasulting in death) L	ditions, mediata tying njury	b		or as e consequence as a consequence								
F	Part II. Other signific	cant conditions	contributing to de	ath but not ras	ulting in the un	dertying causa gi	iven in Part I.	23b. Did tobacco use contribute to the cause of dear					
								175	Yes 2□ No	3 Probably	4 Unknown		
Completed by Physician/N								24a. Wa	s an autopsy ormed?	24b. Wera au evailable completi of death	prior to on of causa		
_								1 📆	Yas 2□No	1 Dyas	2□ No		
4							hor	eath (Check only					
2	25. Was casa retarre examinar?		Hospital:				4 Nursing	ing Homa 5 Residence 6 Other (Specify)					
2	examinar?	No	1		ER/Outpatient	3LI DOA		28d Describe	how injury occur	28d. Describe how injury occurred Whated Charing House 28f. Location (Street and Number or Rural Route Num.)			
2	examinar? 1 Yas 2 N 27. Menner of Death 1 Natural 2 Accident 3 Suicida	No	28a. Data of (Month)	f tnjury n, Day Year) 3 · 99 of Injury - At h	28b. Time of Injury Ome, tarm, stre	28c. Inju		281. Location	Street and Numi	y tobacc			
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2	exeminar? 1 Yas 2 N 1 Hanner of Death	5 Pending invastigative 6 Could not a determined to Cortifying P	28a. Data o (Monti be 28e. Place buildin	f tnjury n, Day Year) 3 · GG of Injury - At hog, etc. (Specification of the control of the contr	28b. Time of Injury Ome, tarm, strey wledge, death	28c. Inju Wo Wo Inju wet, tactory, office occurred at the transition, in my description occurred at the transition, in my description.	iny at ok? [Yas 2 No No No No No No No No No No No No No	28f. Location City or for 1694 Y	(Street and Numi ym, Stata) NE Sustant cause(s) and mi, date and place,	ber or Rural Rout P Rd P Beriner as stated, and due to the c	e Number, roston ause(s)		
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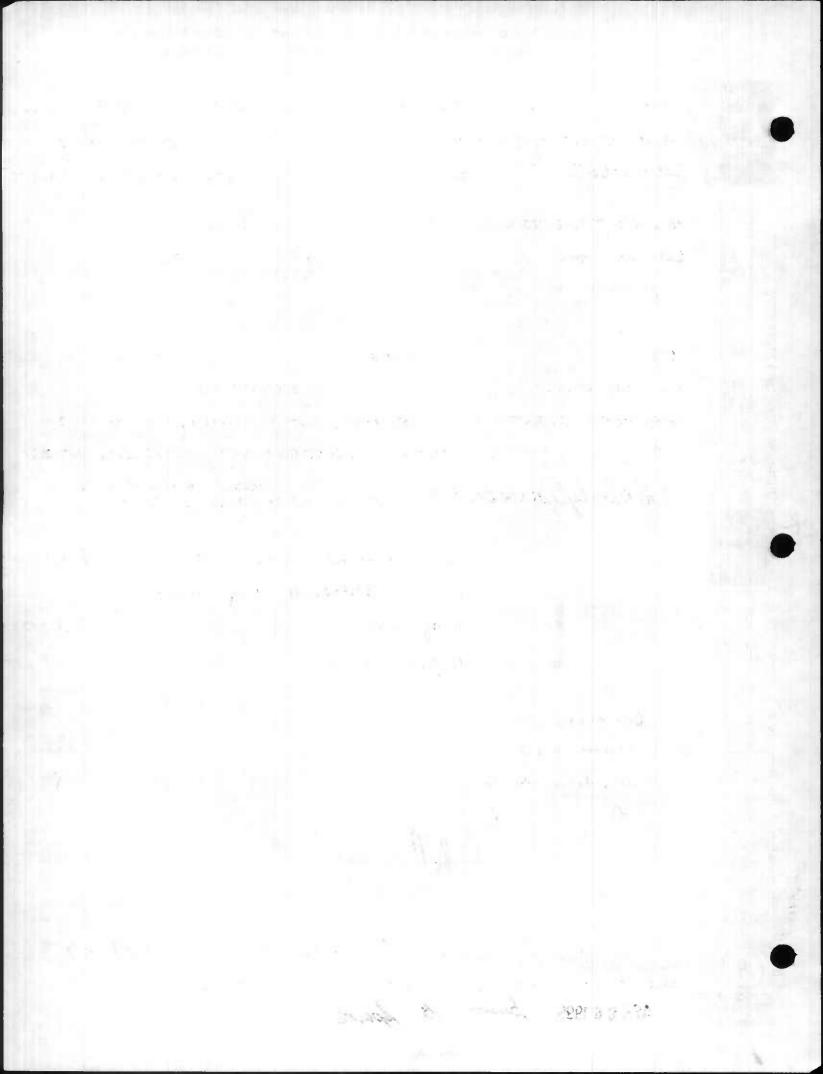


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician DEWEY APRIL LEE CECIL, SR. 1999 20:30 pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 225-48-6670 1 XM 2 ☐ F Yrs **Director** April 27,1939 Marion, VA Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. tnside City Limits ahow r than "natural", or itams 23a or 28a-f ahov the Medical Examiner must be notified at 1 □Yes 2 □ No Director MARYLAND | PRINCE GEORGE'S SUITLAND 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 4702 Huron Avenue # B 20746 daath y USA Funeral Rece - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yee or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married aitlmore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) 6th WELDER PRIVATE 7 is marked other traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pagas 1 and 2 should be fill mant of Haalth and Mental H lant: If item 27 Is marked out Be HENRY WILLIAM CECIL MARGARET GRACE 19a Informent's Neme/Relationship (Type Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) CAROL ROBLES (DAUGHTER) 6531 Parkway Court Hyattsville, Maryland 20782 other 1 20b. Place of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 0 permit. Paga Department of Important: If any Injury or EPIPHANY CHURCH CEMETERY 4-27 FORESTVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licen 22. Neme and Address of Facility MARSHALL'S FUNERAL HOME 4308 Suitland Road Suitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final Bypnso disease or condition resulting in death) Aoria BilateRel FEMUMAI **Examiner** Due to (or es a consequence of): Examiner oastnuctive CHAU MIC Disemy 1474 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last physician and tha burial-tran Due to (or as a consequenca of): that the death certificate be axed Box 68760. MASS Lyna mass

Due to (or se e consequence of): Physician/Medical 98 Dea IED SIDY USB ed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown P Cirr Musis P Sign 24b. Were eutopsy findings evalleble prior to completion of cause ot deeth? 24e. Was an autopsy performed? Completed peen Alcohol AJUSE paga 2 210 No 1 🗆 Yes 1 ☐ Yes 2 ☑ No certificata MUllitu Dia Artes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No director. Be 26. Plece of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 0 this 28a. Date of Injury (Month, Dey Year) funeral 27. Magner of Deet! 28c. tnjury et Work? Certification: 28d. Describe how Injury occurred Aftar Netural 5 Pending after daath. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury - A building, etc. (S) farm, street, factory, office 4 Homleide 24 hours a Hospital Medical 29a. Certifier 1d Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end manner as atated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. To the I within 2 To the I 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) elson 30. Name and address of person ted cause of death (Item 23a) (Type, Print) SAMUEL E. WILSON, M.D. 3001 Hospital Drive Cheverly, MD 20784 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 2 6 1999 Registrar

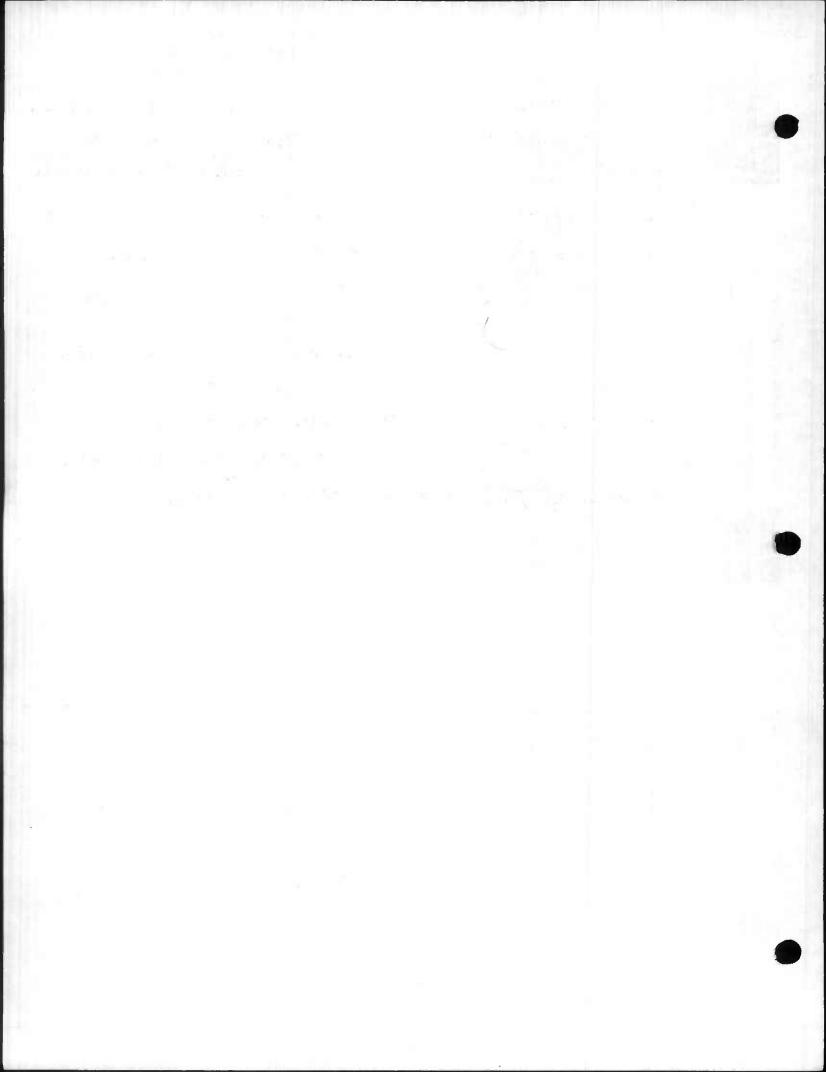
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State of Maryland / Department of Health and Mental Hygiene

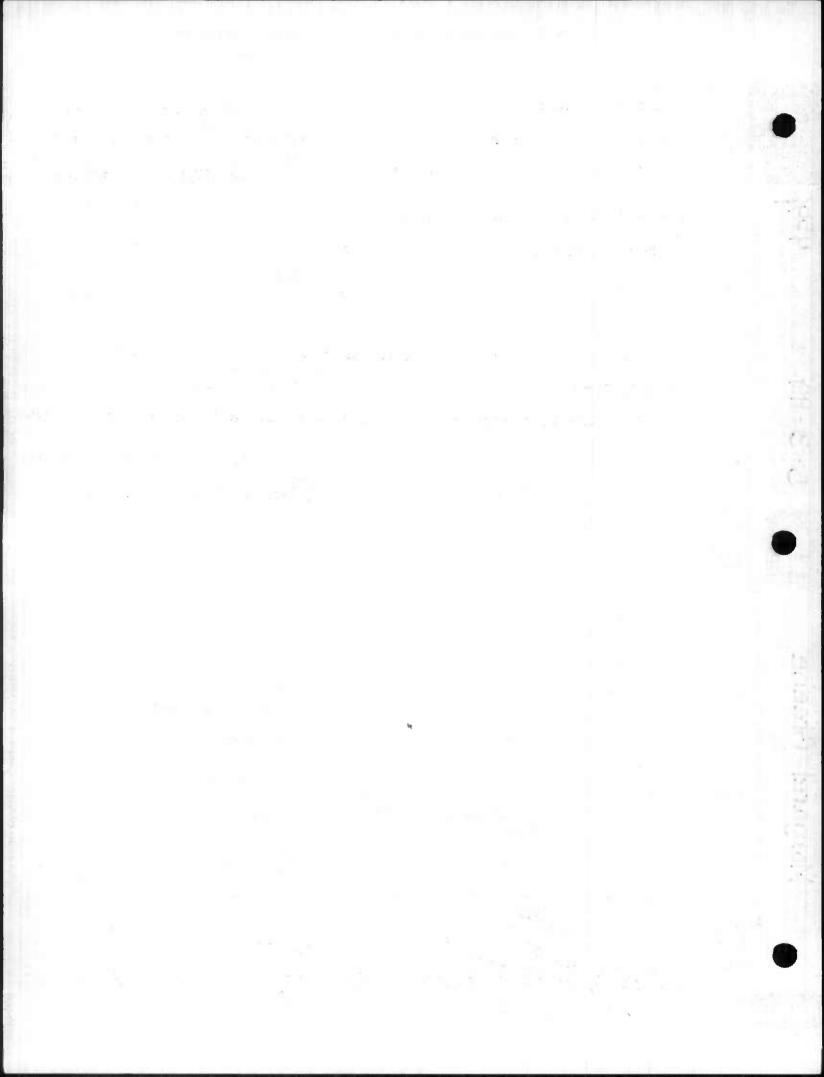
							Ce	rtificate	of Dea	ath		Reg. No.			
	Physic /Medi		1. Decedant's Neme (First, N Wilma Reb					7			2. Deta of D Month May	Deeth	999	3. Time of Deeth 2:30 A.M.	
	Exami		4a. Fecility Nema (If not institution Management)				ter			Hager	Location of Dec	eth 4c. Count	y of Deeth Shing t	ton	
	Funeral Director		5. Social Security Number 204-05-3448	111	ex □ M 2□√F	7. Age (In yrs.) 82	last birthdey) Yrs.	If Under 1 3 Months D	ear If U ays Ho	nder 24 Hr urs Mir	8. Dete of B (Month, I Sept. 1	Sirth Year) 16	9. Birthpi Count West	iace (State or Foreig try) Virginia	
	Marylend f ehow	or	Usuel Residence of Deceder 10a. Stete 10b. Co Md. Was		ton	10c. City	y, Town or Lo	cation lagers t					10	0d. Inside City Limits	
	with the last or 28a-	Direct	10e. Street and Number					10f. Zip Co				10g. Citizen of	Whet Count		
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Medical Examiner must be notified at	by Funeral Director	11. Maritel Status 1 Nevar Married 2 3 Widowed 4 Divo	Married		2⊠No e	'		of Hispeni Cuban, Me		Specify Yes or N rto Rican, atc.)	lo- 14. Re	ce - Amarica ack, White, e	etc.	
21215-0020	vithin 72 ho ne. han "natur nedicel	Completed	15. Dece (Specify only hi		lucation de completed) College (1	-4or 5+)	16a. Deced (Give life.	dent's Usuel O kind of work d DO NOT use r	one during etired)		orking		Business/Industry		
and 2	S should be filed withing and Mental Hygiene. Is marked other than aumatic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men	Be	17. Fether's Name (First, Mid Birtis Hyde	dle, Last)				Hai		Nother's Na		le, Maiden Sume		Salon	
Maryland	and 2 should lealth and Meni n 27 is marked	To	19e. Informent's Name/Relet Larry Edgel	ionship (7					reet end N		lural Route Num	ate ber, City or Town , Md. 217		Code)	
Baltimore,	Page nent c int: If iry or		20e. Method of Disposition Burial 2 Cremet 4 Donetion 5 Other	ion 3 🗆	Remove from S	Date CI	lace of Dispo emetery, crar Lawn	sition (Name onetory or other	of place) ial P	ark N	Dete lay 5,19	20c. Location	-City or Tov	n, Md.	
eg —	Departi Departi Importa any inju		22. Name end Address of Facility 12525 Bradbury Davis Funeral Home Smithsburg, Md. 23.1 Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.									1 Aue. 2178	3		
	Physician /Medical Examiner		shock, or haart failure. Immediate Cause (Final disease or condition resulting In death)	List only	e			emone'		n es cardie	ec or respiretory	errest,		Approximete Interval Between Onset end Deeth	
Box 68/60,	r certificate be executed and physician and use es the burial-trensit	n/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	{	b		es e conseq								
	death e atte	Physician	Pert II. Other significant con-	ditions co	ontributing to dea	ath but not rasu	Ilting in the ur	nderlying caus	e given In I	Pert I.	23b. Die	i tobacco use co	ontribute to	the cause of death	
7	8 50	by	Carcinon	n'h	cardi	respec			-			Yes 2 No	т —	ably 4 ☐ Unknow re eutopsy findings	
Hecords,	has b	Completed	Thouse	and	About	م کرم	take	me	~~		per	formed?	of d	ileble prior to npletion of cause leeth?	
Vital	ician: The certificate rector, pag	Be C	25. Was case referred to med exeminer?	dical					26. 1	Place of De	eth (Check only			165 20 140	
ō	ing Phys After this luneral di	2	1 Yas 2 1-No 27. Manner of Deeth 1 Naturel 5 Pe	nding	Hospitel: 1 In In 28e. Dete or (Month	patient 2 1 Injury In Dey Year)	ER/Outpetien 28b. Time of Injury		Other: 4[Injury et Work? 1 Yes			sidence 6 🗆 Otl)	
Division	al or Attending s efter deeth. I Director: After id in by the fune	Certification:	3 ☐ Sulcide 6 ☐ Co	estigetion uld not be ermined	Zoe. Pieca	of Injury - At ho g, etc. (Specify	me, ferm, str			2 140		on (Street and Number or Rural Route Number, Town, State)			
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical	29e. Certifier (Check only one) 1 □ Oerti	fying Phy cal Exam	rsicien: To the bar iner: On the bar and menn	sis of examineti	vledge, deeth ion and/or inv	occurred et the restigetion, In r	ne time, del	e end plec deeth occ	e, end due to the urred et the time	e ceuse(s) end m e, dete end piece,	enner as ste and due to	ited. the cause(s)	
	To the comple	M	29b. Signature and title of cer		en ste				canse num			29d. Data signe			
			30. Name end eddress of persons. Dr. Vasant Da 31. Dete filed (Manth, Day W.)	tta	334	of deeth (Item Mill St	treet	Hag		own, l	MD 2174	0			
	Sta Registr		31. Dete filed (Month, Day, V	1999	3	ywa a Jiyi10t	uio).	space	2						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Margaret N. Greene May 3, 1999 4:55 PM /Medical 4e. Feclify Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Homewood Nursing Center Williamsport Washington County 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Deys 1 M 2 X F 219-12-1777 77 Yrs. Director Jan. 27, 1922 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Washington Co. Maryland Williamsport Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 USA itema 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Merried 2 Married White altimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondery (0-12) College (1-4or 5+) Real Estate Legal Secretary 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nant of Health and Mental Lula Mae Boward Edgar A. Snyder 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) -Important: if Item 27 is any injury or other tracence. 16505 Virginia Avenue, Williamsport, Maryland 21795 William E. Greene, Jr./Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Department of 1 Burial 2 Cremetion 3 Removel from Stete Rest Haven Cemetery May 8 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme and Address of Facility
Douglas A. Fiery Funeral Home 1331 Eastern Blvd.N, Hagerstown, Maryland 21742 wella 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heardeilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finat disease or condition resulting in deeth) Examiner Examiner sician and burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consi P.O. Box 68760 attanding physician for usa as tha buria Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by tha funaral director, paga 2 should be 24b. Were autopsy findings evallable prior to completion of cause of deeth? Be Completed 24e. Was an eutopsy cartificata has 1 Yea 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpetient 3 DOA Aftar this 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 1 Neturat 2 Accident 5 Pending Investigation daath. within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Sulcide Placa of injury - At home, ferm, atreet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homlcide 🔀 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, and due to the ceuse(s) and menner as stated. 29a. Cartifier Medical completaly (Check only one) On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(a) \$ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of deeth (Item, 23s) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Régistrer's Signeture State MAY 0 6 1999 Registrar

Greene



HELEN	
GLOVER	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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0	1	0	C
	0	0/	5/6

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) HELEN KATHERINE GLOVER 4a Facility Name (If not institution, give street and number)

Month Dav MAY 4b. City. Town, or Location of Death 4c. County of Death

2. Date of Death

Reg. No.

3. Time of Death Year 3, 1999 6:40P.M.

Funeral

9516 BEECH PARK STREET 5. Social Security Number 1□M 2♥F 578-94-6045

UPPERMARI, BORO If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Days Months Hours 37

PRINCE GEORGES 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

Director

show

8 munt be Nerns 23a

'natural', or

Hygiene.

Pages 1 and 2 should be III ment of Health and Mental H lant; If Illem 27 is marked off

Department of Health in Important: if item 27 is any injury or other tre 2008.

Examiner

physician and the burial-transit

USB ō

signed by

page 2

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death.

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after death

To the Hosp within 24 hos To the Fune completely li

lilled in 24 hours a Hospital

the death certificate be executed

68760

Box

P.O.

Records.

Vital

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Division Attending Directo

Funeral

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Completed

8 2

the Maryla 28a-f sh notified

72 hours after

21215-0020

Baltimore, Maryland

10a, State 10b. County Maryland Prince George's 10c. City, Town or Location Upper Marlboro 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number

Usual Residence of Decedent

9516 Beech Park Street

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X If Yes, Give △ Year or Dates:

20747 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA 14. Race - American Indian, Black, Whita, etc.

1 Yes 2 No Specify:

10f. Zio Code

specify: White 16b. Kind of Business/Industry

10g. Citizen of What Country?

July 16 1961 | Washington, DC

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Technician

Telephone Communications

17. Father's Name (First, Middle, Last)

1 Never Married 2 Married

3 Widowed 4 Divorced

18. Mother's Name (First, Middle, Maiden Surname)

David T. Paulos

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4029 28th Av. Temple Hills, MD 20748

Mary Ireland Paulos

Date

David T. Paulos (father) 20a. Method of Disposition 1 Burlay 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cametery, crematory or other place) Metropolitan Crematory 5-5-99

22. Name and Address of Facility

20c. Location - City or Town, State Alexandria, VA

21. Signature of Furgeral Service Licenses

M00173

J.H. Eberwein Mortuary

4433 White Pls La White Pls., MD 20695 Approximate the mode of dying, such as cardiac or respiratory arrest. inter the disease, or complications that caused the death. Do not enter or heart failure. List only one cause on each line.

Physician /Medical

Examiner

Physician/Medical

þ

Completed

8

Certification: To

edicai

Immediate Cause (Final disease or condition resulting in death)

Gunshot of wound Chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Interval Between Onset and Death

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1⊠Yes 2□No

Subject shot

1 Yes 2 No

SXIF

25. Was case referred to medical exeminer? XYes 2□ No

27. Menner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

5-3-99

28b. Time of 28c. Injury at Work? 1 Yes 2 No unknown

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

6 Could not be determined

5 Pending

investigation

26. Place of Death (Check only one)

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 9516 Beech Part

MAY 4,1999

MP 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Stephen 5, 31. Date fled (Month, Day, Year)

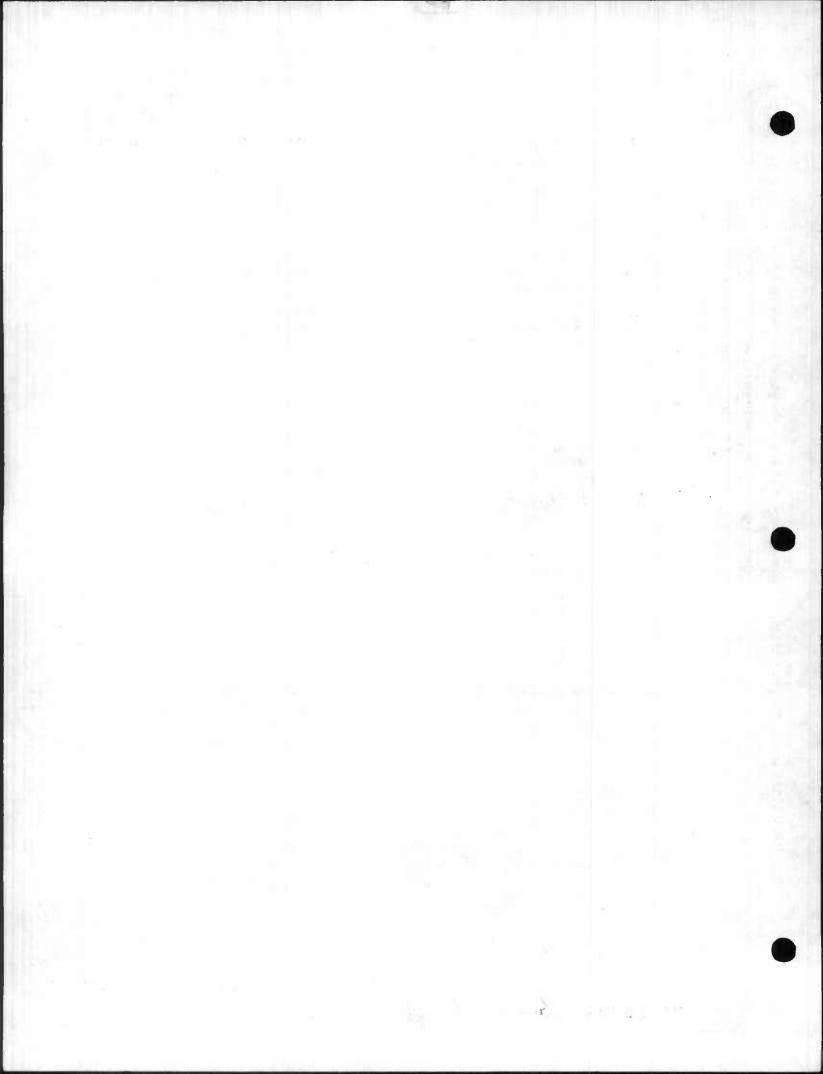
Radentz, 32. Registrar's Signature

MAY 05 1999

111 Penn Street, Baltimore, Maryland 21201

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month 6:20 PM **Physician** mil Walter Lorenz Hammond /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death Examiner 17726 Burnside Avenue Washington Co. Hagerstown If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Dete of Birth (Month, Dey, Yeer) July 7, 1928 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1₩ M 2□ F Months Deys Hours Min 70 Yrs. 212-24-7132 Director Maryland Usual Rasidance of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hagerstown Washington Co Maryland 1 ☐ Yes 2 No Directo 7 is marked other than "natural", or items 23s or 28s-f traumatic svent, the Medical Examinar must be not its 10g. Citizen of Whel Country? USA 10e. Street end Number 10f. Zip Code 21740 17726 Burnside Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Race - American Indien Bleck, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dress Manufacturing Dress Cutter 10 0 18. Mothar's Neme (First, Middle, Meiden Surname) 17. Father'a Name (First, Middle, Last) is 1 and 2 should be file. Heelth and Mental Hitem 27 is marked oth Be Hedwig L. Muench Robert B. Hammond 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 17726 Burnside Avenue, Hagerstown, Maryland 21740 Peges 1 end 2 nent of Heelth a ant: If item 27 is Dorothy B. Hammond/Wife Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Slale 4 □ Donation 5 □ Other (Specify) Depentment of important: If 6 Rest Haven Cemetery May 3 Hagerstown, Maryland 22. Name and Address of Fecility
Douglas A. Fiery Funeral Home 21. Signeture of Funeral Service Licenses Da ummounen 1331 Eastern Blvd.N., Hagerstown, Maryland 21742 23a. Pert1. Enter the disease, or completelions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart sulform. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition rasulting in daath) /Medical Examiner Examine buriel-trensi Sequantially list conditions, if any, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in daeth) Lasi Due to (or es a consequence ot) physician the buriel Box 68760, Physician/Medical Due to (or es a consequance of): 80 9SN 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions-contributing to death but not resulting in the underlying ceuse given in Part I. 0.0 signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was an autopsy performed? Completed 1 Tes 2 No 2 D(10 certificate Hospital or Attending Physician: 25. Was casa raterred to medicel axeminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residance 6 Othar (Specify) To 1 Yes 28 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day(Year) funeral 27. Mannar of Death 26d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Panding 1 Natural efter deeth. Director: Aft 1 Ye investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Fown Stete) 4 Homicide 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) end manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) ş 29d. Date signed (Month, Dey, Year) 29b. Signature end little of certifier 29c. License number 0 L 30, Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 66 MILL ST HAG BRETOUXING MI UK 31. Date filed (Month, Day, Year)

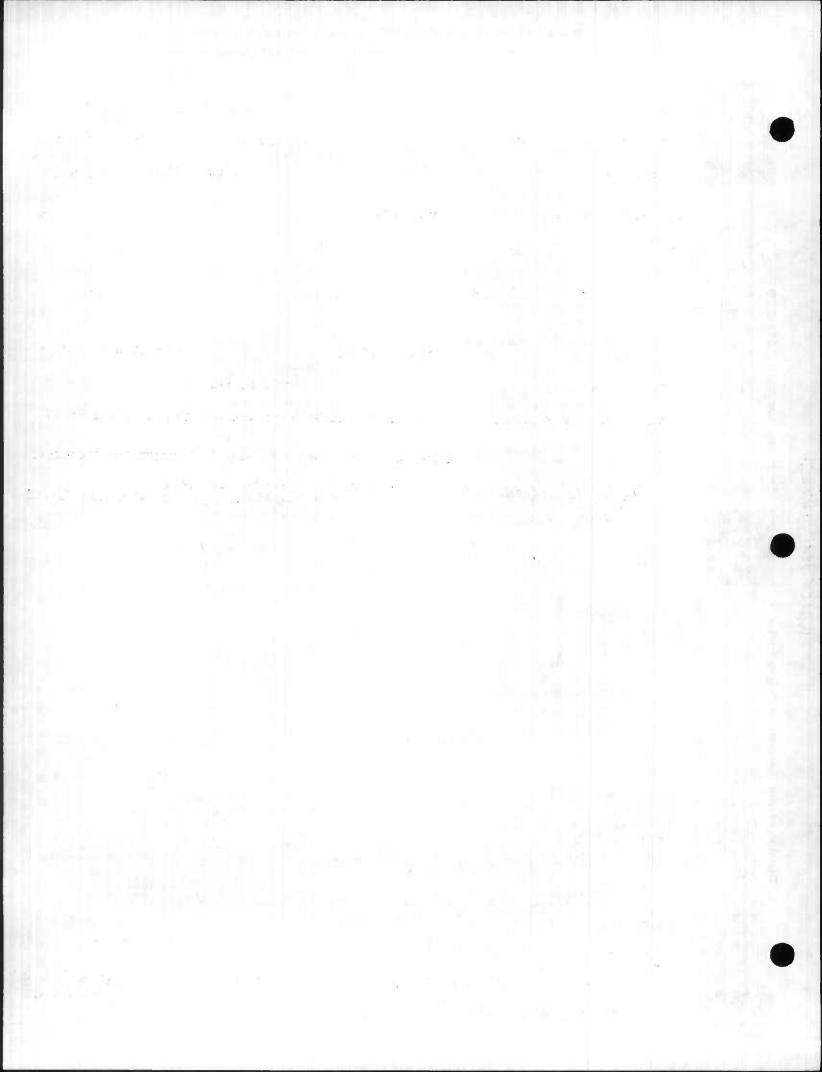
DHMH 16 Rev 6/95

Hammon

Registrar

MAY 0 3 1999

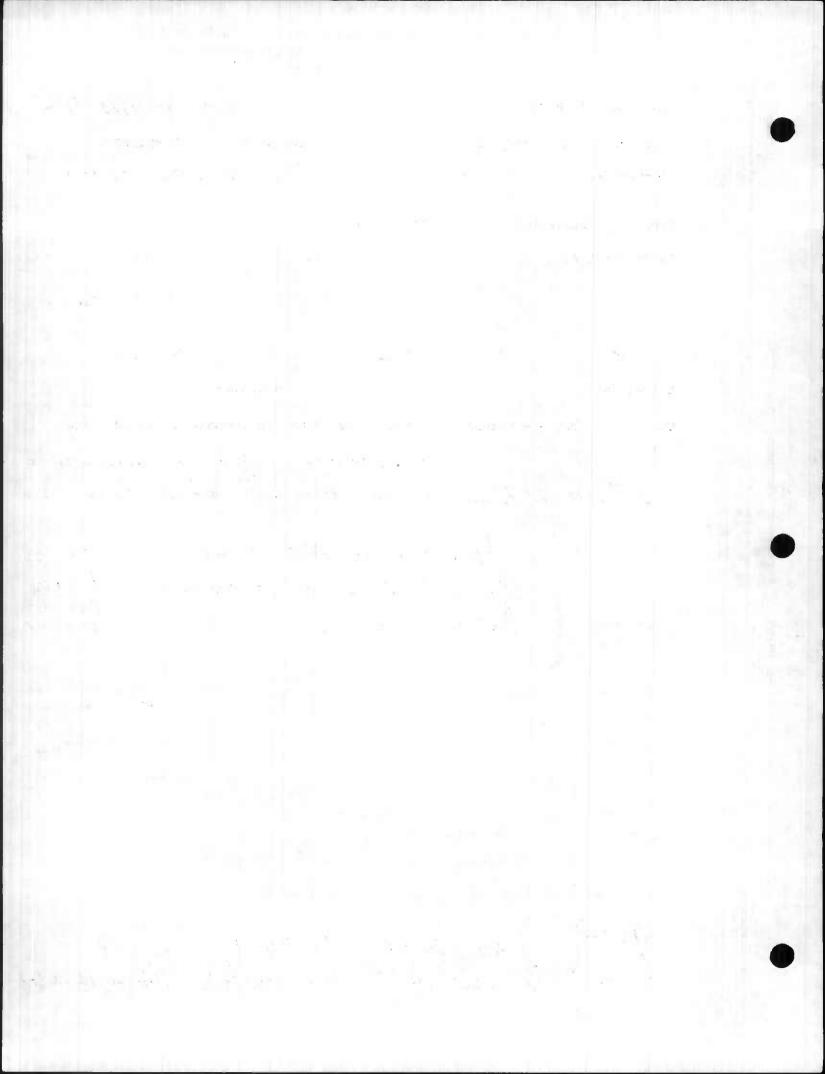
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

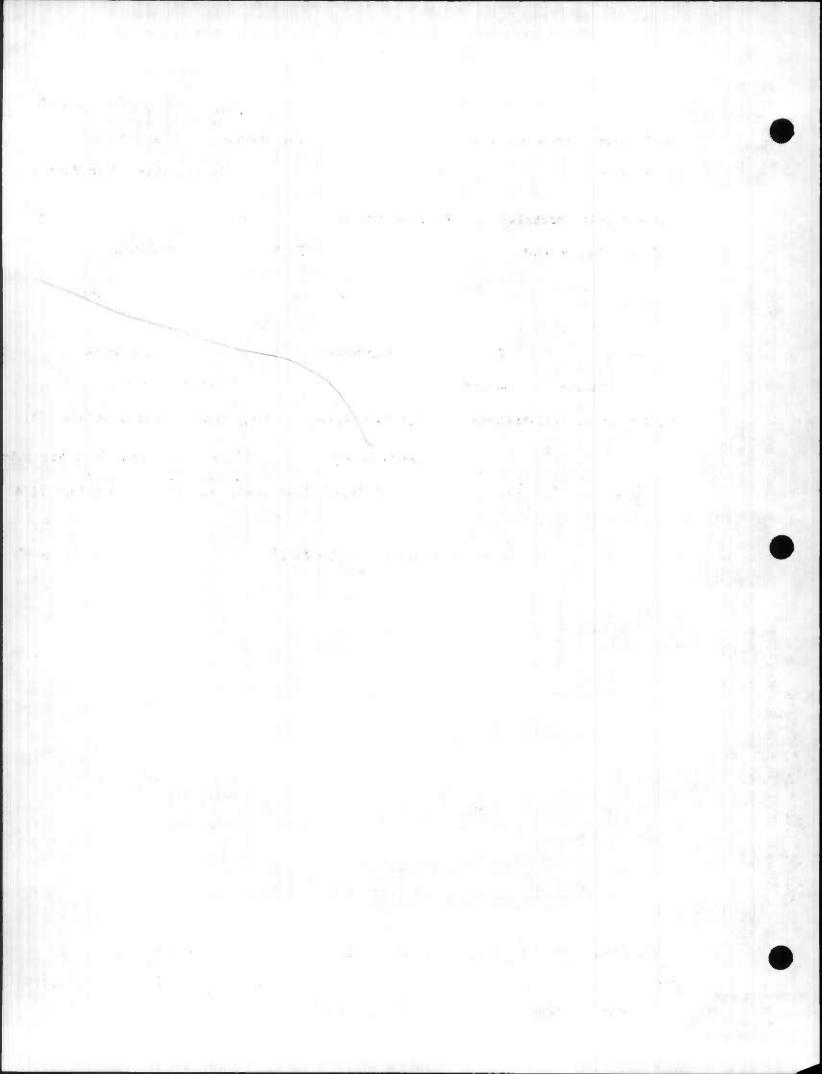
	Certificate of Death		Reg. No.	
	1. Decedent's Neme (First, Middle, Last)	2. Dete of D	Table -	3. Time of Death
Physician	Elsie Lavinia HAUSE	Month	Day	999 1505
/Medical Examiner		, or Location of Dea	th 4c. County of	Deeth
Examinet	Washington County Hospital Hagara	town	Washing	rton
	Washington County Hospital Hagers 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Dete of B	irth s	D. Birthplace (State or Foreign Country)
neral ector	214-46-5371 1□ M 2♥ F 84 Yrs. Months Days Hours			
	Usuel Residence of Decedent	NOV.	2 1914	Maryland
	10a. Stele 10b. County 10c. City, Town or Location			10d. Inside City Limits
ō	Manual and Washington Hannaharm			1 ☐ Yes 2 No
2	Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	et Country?
ā				
20	14429 Marsh Pike 21742	2 (Casait, Vac or N	U.S.	A. American Indien,
Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	Black,	White, etc.
by F	1 Never Married 2 Married 1 Yes 2 No lt Yes, Give 1 Yes 2 No Specify:		Specify:	White
	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			
Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most o	f working	16b. Kind of Bush	ness/industry
npf	Elementery/Secondery (0-12) College (1-4or 5+)			
20	0-10 0 Homemaker		Her own	
Be (17. Fether's Neme (First, Middle, Lest) 18. Mother's	Name (First, Middle	e, Maiden Sumeme)	
0	Lester Kaiser Annie	C. Mummer	rt	
_	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number of Street and Number of	or Rurel Route Num	ber, City or Town, S	ete, Zip Code)
	Clarence L. Hause - Husband 14429 Marsh Pike	Hagerstown	n Marvlar	nd 21742
	20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other placa)	Dete	20c. Location - C	
	1 ABurial 2 Cremation 3 Chemovel from State	F / F / O O	***	16 1 1
	4 Donetion 5 Other (Specify) Rose Hill Cemetery	5/5/99		own, Maryland
	21. Signature of Funerel Service Licansee 22. Name end Address of Facility			
	Scott Minneed 415 E. Wilson Bi	lvd. Hage	erstown, I	Maryland 21/4
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cashock, or heart failure. List only one cause on each line.	ardiac or respiratory	errest,	Approximate interval Between
	11			Onset and Death
	immediate Cause (Final	CANDIK	1	GONAS
	immediate Cause (Final disease or condition resulting in death) e. UENTRICULAN TARTY Due to (or an a consequence of): b. AUTE MYD CANDIAN I	91.47	,	11
è	HALTE MUD COAD (CO	11 = Ann	77.00	MINUTER
Examiner	b. Thate perochapital	WE MINE	1240	The
Xa	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease of Injury c			1000
E E	Cause, Enter Underlying Ceuse (Disease or Injury c. \\\ \tag{\tag{CQUIVE}}			DECADO
edical	that initiated events resulting in deeth) Lest Due to (or es e consequenca of):			
3	d			
8				
Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. DI	d tobacco use cont	ribute to the cause of death
P		10	Yas 2 No	Probably 4 Unknow
by				
Completed by		24a. Wa	is en autopsy formed?	24b. Were autopsy findings available prior to
pie		_		completion of cause of death?
E		10	Yes 2 No	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical 26. Place of			
Be C	examiner?	of Death (Check only	1	(0
. To	1 Inpatient 2 ENOutpatient 3200A 4 Nurs		sidence 6 Other e how injury occurre	
Certification:	1 Netture 5 Pending (Month, Dey Year) Injury Work?		s now injury occurre	u .
Cat	2 Accident investigation 3 Suicide 6 Could not be			
E	4 Homlcide determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location City or T	(Street and Number own, Stete)	r or Rural Route Number,
S				
edicai	29e. Certifier (Check only) 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth			
B	and manner stated.	occanion at the thin	o, doto ond plood, or	a due to the outloots)
Σ	29b. Signeture and title of gentifier 29c. License number		29d. Dete signed	Month, Day, Year)
	The IFAMUS HUMAN 1701		(72/	49
	30 Name end eddress of person who completed cause of death (from 23e) (Type, Print)		3/7/	1 /
	30 Mame end eddress of person who completed cause of death (Item 23e) (Type, Print)	11/1/15-	- Has	MITOIMILL
	21 Date field (Month Day York)	TUE	· Umo	- 1 1 2000
ate	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture			
rar	MAY 0 4 1999 . sparks			

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death		P	leg. No.		0/09	
Diameter terr	1. Decedent's Neme (First, Middle, L	ast)						2. Dete of Dee Month	th	Vear	3. Time of Deeth	
Physician /Medical	Garnet	Evelyn HA	LL					May	04,10	799	2030	
Examiner	4e Fecility Neme (If not institution, g.							ation of Deeth	4c. County			
الجيبي	Washington Coun	-		W Hee	der 1 Year		ersto		Wash			
uneral irector	5. Social Security Number 6. 232-58-6201 Usual Residence of Decedent	Sex 7. Age 1	(In yrs. last bir	Yrs. Month		Hours	Min.	8. Dete of Birth (Month, Day July 1	Year) 1, 1938	9. Birthi Coul Wes	olece (State or Forentry) st Virgin	
ž	10e. State 10b. County		10c. City, Tow	n or Location						1	Od. Inside City Lim	
Ba-f should be street a	West Virginia Be	rkeley	Falli	ng Wate	ers						1 ☐ Yes 200	
r tems 23s or 28s-f s rings must be notified Funeral Director	131 Twin Falls	West		10f. 2	Zip Code	2541	9	1	_	Citizen of Whet Country?		
by by	11. Maritel Status 1 □ Never Merried 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2X No If Yes, Give Yeer or Detes:				Hispenic Origan, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	14. Rac Blec	k, White,	can Indien, etc. white	
dicel dicel	15. Decedent's I (Specify only highest g		16e.	16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business/Industry			
s marked other than natural summits event, the Medical To Be Completed	Elementary/Secondery (0-12)	College (1-4or 5-	-)					own home				
5 0	0-9 17. Fether's Neme (First, Middle, Las	0		nome	maker		r's Nome	(First Middle			ne	
eve ve	Charles	Carter				18. Mothe	I S Neme		First, Middle, Meiden Sumeme) Pauline Hurtt			
To To				5.6 W. 6.44							0-4-1	
em 27 ls ma	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Mr. Ernest R. Hall/husband 131 Twin Falls, Falling Waters, West Vi 20e. Method of Disposition 20b. Place of Disposition (Name of								Vir	ginia 254		
Important: If Nem 27 any Injury or other tr once.	20e. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Special Contents)		cemete	Disposition (A ry, crematory o y Cemet	r other pla	ice)		/8/99	Glendo	on, k	lest Virg	
physician and modern a medical environment and modern a	Minnigh Fungaral											
	Immediate Cause (Final disease or condition resulting in death)	e. Cer	Oue to (or as a	consequence		No?	+		N House		2/2 40	
	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Lest	c	Due to (or es a									
d by the attending pleased for use as		d										
yslo	Pert II. Other significant conditione								id tobacco use contributa to the ceuse of dec			
8.0		1□ Yee 2☑ No								3 Pro	bably 4 □ Unki	
should be								24e. Wes a	an autopsy med?	CO	ere autopsy finding raileble prior to empletion of cause death?	
certificate has rector, page 2 Be Comp								1 D Y	es 2 No	1	Yes 2 No	
ector, p	25. Wes case referred to medical					26. Plece	of Deeth	(Check only or	ne)			
I direct	examiner? 1 Yes 2 No	Hospitel:	t 2 ER/Ou	tpatient 3	DOA Ot	her: 4 Nu	irsing Hom	ne 5 Resid	ence 8 Oth	er (Speci	fy)	
	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigeti	28e. Dete of Injury (Month, Day	28b.	Fime of njury	28c. Inju Wo	ryet ork?]Yes 2□		8d. Describe h	ow Injury occur	red		
in Director: After I led in by the funer Certification:	3 Suicide 8 Could not determine		ry - At home, fe (Specify)	rm, street, fect	lory, offica		2	8f. Location (5 City or Tow	itreet and Numb n, State)	per or Rur	al Route Number,	
To the Funeral Dir completely tilled in Medical Cert		hyaician: To the best of minar: On the bests of end menner state	examinetion en									
Mex Mex	29b. Signature end title of certifier	Sind marking stat			29c. Licen	se number			29d. Date signe	d (Month,	Dey, Year)	
F 8	Gredere 1	Ulin	h	0 1	75.	3623		1	may 5	-	1999	
			- Ab / /A age Off a l	- D-1-41					- Committee			
	30. Name end eddress of person who	completed cause of de	L LAA	(Type, Print)	Oh	achs.	11	dan-Ad	n P.	1 1	acento	



99-2621-04		Type or Print in	Black Ind	lelihle In	k Accure	VII Conles	Are Legi	hla			
B.K.S JAMES HOOF	PER	State of Maryla	and / Depa	rtment of	Health and		_	1 5	770		
ITEMS: #23	PART I, 27, 28A F PER M		R. Cen	tificate o	f Death		Reg. No.		10		
Physician	Decedent's Neme (First, Middle, La.	st)				2. Dete of De Month	ath Day	Year 3.	Tima of Death		
/Medical	JAMES EVI	EREIT	HOPPE	R		MAY '	7, 1999	1	1:35 AM		
Examiner	4a Facility Name (If not institution, given PENINSULA REGIO				4b. City, Town, or		,				
3				#11 1 - V	SALISBU		WICOMICO				
Funeral Director	5. Social Security Number 6. S 219–06–7602 1 Usual Residence of Decedent	ex 7. Age (in y. 14	rs. last birthday) Yrs.	Months Dey		(Month, Da	th ly, Year) 2r 2,1984	9. Birthplace (Country) Maryl	Stete or Foreign		
M M M	10a. Stete 10b. County	10c.	City, Town or Loc	ation			10d. Inside City				
death with the Manyand ms 23s or 28s-f show creat be notified at	Maryland Wicon	nico	Hebron				1 ☐ Yes 2 ☐				
or 28a-f s be notified	10e. Street and Number			10f. Zip Code	9	T	Vhat Country?				
23s or unit be				2183			USA				
fler death v fler death v fler mat for mat	11. Marital Status	12. Was Decedent Ever in	U.S. 13. W		f Hispanic Origin? (S uban, Mexican, Puer	e - American Inc	dien.				
Fire Bar	Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2 ☒ No	H	Yes, specify C	uban, Mexican, Puer	to Rican, etc.)	Blac	k, White, etc.			
The Care	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2XIN	lo Specify:		Specify	White	2		
l Z I Z I S-U led within 72 ho tygiene. Ner then "neturn it, the Medical	15. Decedent's Ed		16a. Decede	ent's Usuel Occ	cupation	dia	16b. Kind of Bu	usiness/Industry			
Man al	(Specify only highest gra	College (1-4or 5+)	ne during most of wo ired)	rking							
A Part a	9	_	Stu	dent			cation	tion			
D STROPE OF	17. Father's Neme (First, Middle, Last)				18. Mother's Na	me (First, Middle	Maiden Surnam	10)			
Went Went His s		ppper			Joyce	Ann Harr	ris				
2 sho	19a. Informent's Neme/Relationship (Type, Print)	19b. Meiling	Addrass (Stre	et end Number or A	ural Route Numb	er, City or Town,	State, Zip Code)		
of Health of Hea	Joyce A. Hopper/M	lother	P.O.	Box 46	8, Hebron	, MD 218	330				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐		. Plece of Dispos cemetery, cremi		olece)	Dete	20c. Location -	City or Town, S	tete		
Pag Pag International	4 Donetion 5 Other (Specify		Hebron C	emetery		5/11/99	Hebro	on, MD			
Demit. Departiment eny inj	21. Signatural of Funeral Barylos Licen	enle des	He	olloway	ress of Fecility Funeral Hill Rd.	Home Pro	fession	al Asso	ciation		
J	23a. Part1. Enter the disease, or comp shock, or heert failure. List only	olication, that caused the de one cause on each line.	eath. Do not ente	r the mode of o	lying, such as cardia	c or respiratory e	rrest,	Appr	oximete val Between et end Death		
Physician /Medical	Immediate Cause (Finel)	N GING CORNI		
Examiner	disease or condition resulting in deeth)	ALVEOLAR HEMO	RRHAGE SYN	IDROME							
		Due to	(or es e consequ	ience of):							
d d da da da da da da da da da da da da		b						i			
execution and rial-tra	Sequentially list conditions, If any, leeding to immediate										
		Cause. Enter Underlying Cause (Disease or injury c.									
certificate be refined physicis	resulting in death) Last	Due to	(or es a consequ	ence of):				-			
eeth certification attending of the use as	No. of the last	d									
deeth cer e attendir ed for use	Control Contro					L con mile					
at the deeth certification of the attending etached for use at Physician/M	Pert It. Other significant conditions of	ontributing to death but not r	esulting in the uni	derlying cause	given in Pert I.		tobacco use co Yes 2□ No	3 Probably			
be de									•		
been should							an autopsy ormed?	available	atopsy tindings a prior to ion of cause ?		
The law ate has pege 2						120	Yes 2 No	12 Yes	2 No		
certificate rector, per					26 Place of De	eth (Check only o		77(1)			
Physician: rthis certificant director,		Hospitel: 12 Inpatient 2	☐ ER/Outpatient	3□ DOA	Other	Home 5 ☐ Resi		er (Specify)	15.5		
7 4 4 4		28a. Date of Injury	28b. Time of	28c. In			how injury occur		RE TO		
tion of fun	1 □ Natural 5 □ Pending investigation	(Month, Day Year)	UNKNOWN		Vork? ☐ Yes 2 \ No	CHEMICAL	VAPORS				
or Attanding after death. Director: After d in by the fune	3 Suicide 6 Could not be determined	28e. Place of Injury - Al	home, ferm, stre	et, factory, offic	28	28f. Location (Street and Numb	er or Rural Rou	te Number,		
be or Attanding P is after death. al Director: After the funer od in by the funer Certification:	4 Homicide	GARAGE OF FR	cify)			City or To	wn, State) ICOMICO CO				
		reician: To the best of my k			time, date and place				TEMNU		
Ne Hosp n 24 hou ne Fune pletely fil	(Check only Medical Exam	iner: On the basis of exami and manner steted.							ause(s)		
Me th				29c. Lice	ense number		29d. Date signe	d (Month, Day,	Year)		

To the Hospital or Attan within 24 hours after deal To the Funeral Director: completely filled in by the

State

Registrar

29b. Signature and title of certifier

29c. License number O.C.M.E

29e. Certifier
(Check only one)

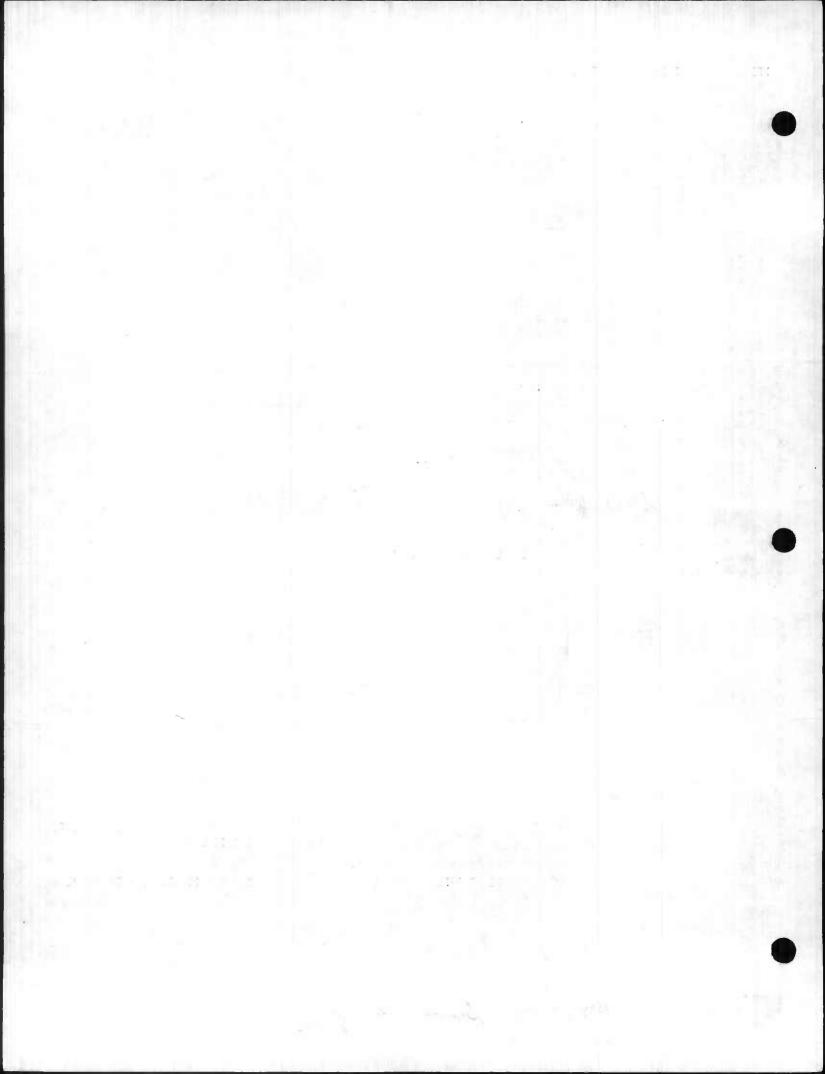
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MAY 8, 1999

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

Stropyn S. Padent 111 Penn Street, Baltimore, Maryland 21201 Radentz

Strphyn S. 1200 31. Date filed (Month, Day, Year) MAY 12 1998 32. Registrar's Signeture



99-2635-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

PAUL HISLEY	JR.	. ITEMS: #23 PART I, I	I, 27 PER MEO	yland / G772	Department of Certificate of	Health and M	R	eg. No.	15	771
Physic /Medi Examin	cal	Decedent's Neme (First, Middle, L Paul David H. Facility Neme (If not Institution, gi	isley			4b. City, Town, or Lo	2. Dete of Dear Month MAY ocation of Death	8, 10 4c. County	Year 999 C	Time of Death
Funeral Director		01 - 01		in yrs. last b	oirthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day) NOV 2	Vaar	9. Birthplace Country) 8 Mar	e (State or Foreign yland
after death with the Maryland or Items 23a or 28a-f show risher, mast be inclified at	Director	10a. Stete 10b. County Baltin	more		wn or Location timore			0- 00		fnside City Limits № Yes 2 No
a 23a or must be r	eral Dir	712 S. Curley	St.	er in II S		224			SA - American I	
5-0020 72 hours after di	by Funeral	11. Mentel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	er in U,S.	13. Was Decedent of ff Yes, specify Cul		Rican, etc.)	Blac	k, White, etc. White	
21215-0020 d within 72 hours at glene. r than "hatural", or the Medical Exam	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4or 5+)	16	Decedent's Usuel Occu (Give kind of work done life. DO NOT use reting	during most of work ed)	ing	16b. Kind of Bu	siness/Indust	Ŋ
		2 17. Father's Neme (First, Middle, Las			Never Emp	loyed 18. Mother's Neme	e (Einst Middle)	N/A	4)	
id be id be ded of c eve	o Be	Paul T. Hisley					D. Przy		0/	
, Maryland and 2 should be file alth and Mertal Hy 27 is marked other or traumetic event	-	19a. Informant's Neme/Reletionship. John T. His	(Type, Print) Ley	19	ob. Meiling Address <i>(Stree</i> 77 E. Main	st and Number or Run St, Faw	al Route Number	City or Town,	State, Zip Co. 17321	de)
Baltimore, permit. Pages 1 a Department of Hes Important: if Isem any Injury or othe ange.		20e. Method of Disposition 1 Burial 2 Cremetion 3 (4 Donation 5 Oother Special Control of Fundral Service Lion	Removel from State	20b. Plece cemet Eawn Eawn	of Disposition (Name of ery, cremejory or other plus of the plus o	ess of Fecility J		Penn tenste	sylva in Mo	nia rtuary,
Physician /Medical Examiner	her	23a. Part Limber the day ese, or cor shock to hear failure. List only Immediate Cause (Finel disease or condition resulting in deeth)	a. ATHEROSCLE	ROTIC (CARDIOVASCULAR consequence of):		or respiretory em	est,	Inte	proximate ervel Between iset and Death
C DS / DU, ntificate be assecuted ng physician and ass the bunal-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	c		a consequence of):					
COIGS, P.O. BOX 68/V requires that the death certificate been signed by the attending physishould be detached for use as the	Physiclan/Medi	Pert If. Other signiffcant conditions	contributing to death but n	ot resulting	in the underlying cause g	iven in Pert I.				cause of death?
7 te 2 te	by Pi	DIABETES MELLITUS. S	EIZURE DISORDE	R			104	es 2□ No	3 Probabi	ly 4 Onknow
INVISION OF VITAI RECORDS, P. I or Attending Physicien: The law requires that after death. Director: After this certificate has been signed by the funeral director, page 2 should be detailed.	Completed						24a. Wes a perior	med?	evailat compli of dea	autopsy findings ble prior to etion of cause
VITAL INITIAL INITIAL INITIAL INITIAL INITIAL INITIAL INITIAL INITIAL INITIALI INITIAL INITIAL INITIAL INITIAL INITIAL INITIAL INITIAL INITIA	Be	25. Was case referred to medical examiner?	Hassital			26. Place of Deet	h (Check only on	96)		
Physic this oral dir	. To	1) Yes 2□ No 27. Manner of Death	Hospitel: 1 Inpatient 28e. Dete of Injury	1	outpatient 3LI DOA		me 5 Reside			3.11
OVISION OF VITA or Attending Physicien: after death. Director: After this certific i in by the funeral director,	Certification:	1 Detural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigetic 6 Could not I	OB Disease finite	- At home,	Injury Wo	Yes 2 No	28f. Location (Si City or Town	reet and Numb		oute Number,
LIVISION OT VICAL Heel To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Cel	29e. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of m miner: On the basis of ex end manner steted	aminetion e	ge, deeth occurred et the t nd/or investigation, in my	ime, date end place, opinion, death occurr	and due to the cred at the time, d	ause(s) and me ate and place, a	nner as state	d. cause(s)
To the Withir To the comp	Me	200. Signature and title of certifier	anu M	S.		se number	2	9d. Date signed MAY 9,		Year)
Sta	te.	30. Name and address of person who	completed cause of death	tour		n Street,	Baltimo	ore, Mar	yland	21201

Registrar

DHMH 16 Rev 6/95

MAY 8 1999 | Bener & Sparke

Mr 1924 James to Space

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

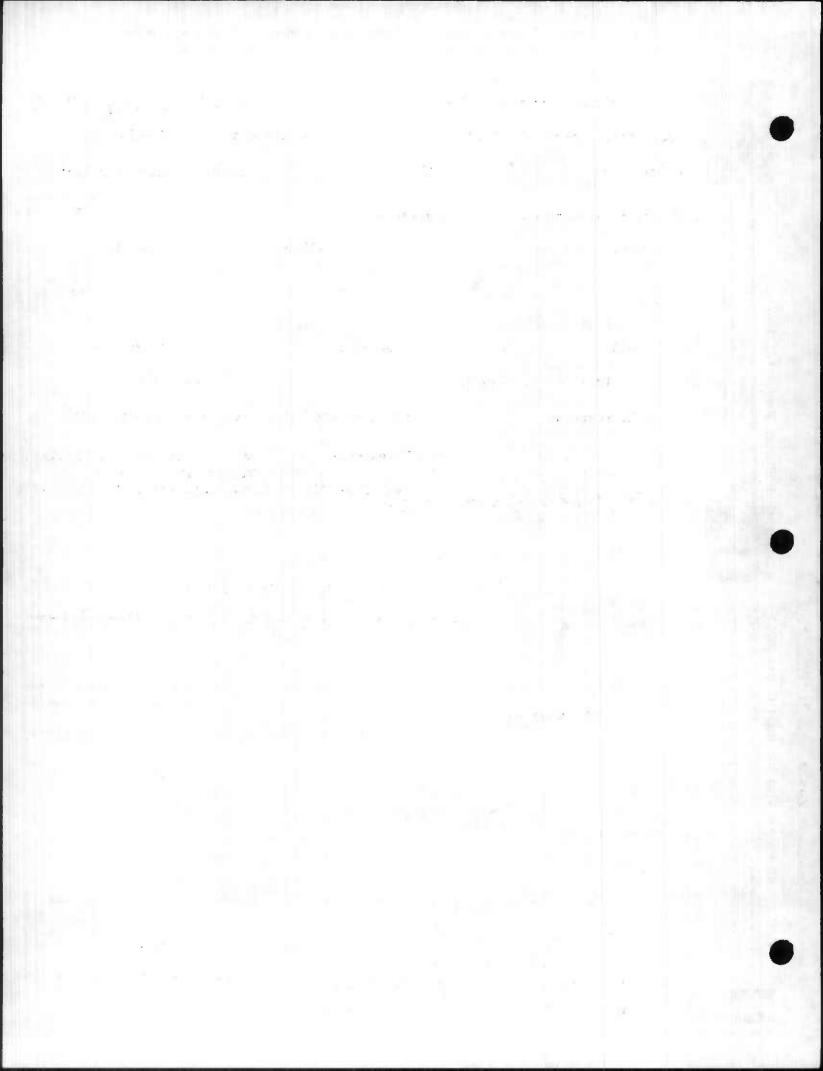
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

hysician	 Decedent's Neme 	/Einst Atidalla I a											
/Medical	1	Marie Jo	osephine	KNAP	Р					April	3 o	1999	3. Time of De 08:43
xaminer	4a Facility Nama (III Washingt		e street and number y Hospita				4	b. City, To Hage		ocation of Deat WIL		nty of Death hingto	on
ineral ector	5. Social Security No. 217-12-18	umber 6. S		Age (In yrs.	last birthday) 75 Yrs.	If Under 1 Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D. Sept.	rth ay, Year) 9, 1921	9. Birthi Coul Mar	plece (Stete or Fo
*=	Usuel Residence of 10a. Stete	Decedent 10b. County		10c. City	y, Town or Lo	cation		-					10d. Inside City L
notified at		Washing	ton		gersto								1X Yes 2[
or 28a	10e. Street and Nun					10f. Zlp (4.7.4.6			10g. Citizen		nfry?
rai [125 Nott:	ingham Ro	,					1740				S.A.	
riked other than "natural", or fame 23e or 28e-fe tite avant, the Medical Examiner must be nothing. To Be Completed by Funeral Director	11. Marital Stetus 1 □ Never Marrie 3 □ Widowed		12. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Dete	s? No		Wes Decede If Yes, specif 1□ Yes 2		ispanic Or in, Mexice Specify		ecify Yes or N Rican, etc.)	Spe	ace - Amari leck, White, cify: W	
edical Expedical Exp	(Spec	15. Decedent's Edity only highest gra			16a. Deced	dent's Usuel kind of work	Occup	ation	et of work	rlna	16b. Kind of	Business/In	dustry
the Med	Elementery/Secon		College (1-40	or 5+)	life. I	creta:	e retired	1)			acco	unting	3
important; if item 27 is marked other than any injury or other traumatic avant, the than bace. To Be Comp	17. Fathar's Neme (W. Linds	say				18. Moth	er's Nem	e (First, Middle Iva I	. Meiden Sum		
raumetic av	19e. Informent's Ne									ral Route Numi			
ther t	John E.		n	20b. F					e, r	ork, Pe			17402 own. State
mportant: If item 27 any injury or other transfer.	12 Burial 2		Removel from Ste	18	Place of Disponentery, cremetery, cremetery					May 4,1999		Location - City or Town, Stete gerstown, Mary	
eny inju	21. Signature of Fu	nertil Service Licer	MM.		1.2	5 Eas				innich d. Has			e ryland 2
ician	23e. Pert1. Enter th shock, or heer	ne diseese, or com 1 feilure. List only	plications that caus one causa on aach	sad the daat	h. Do last ent	er tha mode	of dyln	ig, such as	cardiac	or raspiretory	errest,	1	Approximete Interval Betwee Onsat and Dea
edical miner	Immediate Ceuse (Finel											
	disaase or condition	n	e. Acut	2 450	cratio.	^						9	Kaurs
- 07	resulting in death)	n	e. Aut		r es e consec	quence of):		-		/^	1	1	
ě	resulting in death)		e. Acut	Due to (o	r es e consec	quence of):		Ta		L /As			Jacre
nding physician and use as the buriel-transit in/Medical Examiner	Sequentially list cor if any, leeding to in ceuse. Enter Unde Ceuse (Diseese or thet initieted events resulting in daeth) L	nditions, mediate rlying injury	bi.	Due to (o	Res e consecutive es a	quence of): quence of): to	rep.					Asom	
nding physician and use as the buriel-transit in/Medical Examiner	Sequentially list cor if any, leeding to in ceuse. Enter Unde Ceuse (Diseese or thet initieted events resulting in daeth) L	nditions, mediate rlying injury .ast	b	Due to (o	rese consec	quence of):	Repo	wh	f 2	herrica -	tel		Jacre
nding physician and use as the buriel-transit in/Medical Examiner	Sequentially list cor if any, leeding to in ceuse. Enter Unde Ceuse (Diseese or thet initieted events resulting in daeth) L	nditions, mediate rlying njury .ast	b. C. Post	Due to (o	rese consec	quence of):	Repo	wh	f 2	23b. Dic	tobacco use	contribute t	years nd lws
gned by the attending physician and be detached for use as the buriel-trensit by Physician/Medical Examiner	Sequentially list cor if any, leeding to he ceuse, Enter Under Ceuse (Disease or intel initiated events resulting in daeth) L	nditions, mediate rlying njury .ast	b	Due to (o	rese consec	quence of):	Repo	wh	f 2	23b. Dic	tobacco use	contribute to 3 Pro	Jacks Lws
has been signed by the attending physician and ge 2 should be detached for use as the buriel-frensit mpleted by Physician/Medical Examiner	Sequentially list cor if any, leeding to he ceuse, Enter Under Ceuse (Disease or intel initiated events resulting in daeth) L	nditions, mediate rlying njury .ast	b. C. Post	Due to (o	rese consec	quence of):	Repo	wh	f 2	23b. Did	tobecco use Yes 2 N s an autopsy	contribute to 3 Pro	to the cause of cobably 420n Vere autopsy find valiable prior to omplettion of cause
ordinate has been signed by the attending physician end sctor, page 2 should be detached for use as the buriel-frensit. Be Completed by Physician/Medical Examiner	resulting in death) Sequentially list cor if any, leeding to imceuse. Enter Under Ceuse (Disease or ithet initiated events resulting in death) L Pert II. Other eigniff	nditions, mediate rlying injury ast	b. in.	Due to (o	rese consec	quence of):	ause giv	ven In Part	1.	23b. Did	tobacco use Yes 2 N s an autopsy ormed?	contribute to 3 Pro	to the cause of cobably 420n Vere autopsy find valiable prior to completion of cause deeth?
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State of Maryland / Department of Health and Mental Hygiene

15773

				Certific	cate of	Death	F	Reg. No.		
Physician /Medical	1. Decedent's Name (First, Middle Ruth Mati	lda Kinsey					2. Data of Dea Month	Day	Year 799	3. Time of Death 5: 10 A
Examiner	4a Eacility Name (If not institution Coffma J NU)					4b. City, Town, or Hagerst	Location of Death	Was	hingt	
Funeral Director	5. Social Security Number 173-03-2084	6. Sex 10 M 20 F	Age (In yrs. Ia 90		nder 1 Year ths Days			,1908	9. Birthpl Count Mary	aca (Stata or Fore
	Usual Residence of Decedent 10a. Stata 10b. County		10c. City,	Town or Location					10	Od. Inside City Lim
be notified at Director		ington		Smithsbu						1 □ Yes 2 💢
	10e. Street and Number 55 E. Water	St.		10	1. Zip Code 217	783		10g. Citizen of W U.S		ry?
Examinar must	11. Marital Status 1 Never Married 2 Man 3 Widowed 4 Divorced	If Yes Give	s? XNo		ecedent of h specify Cub es 2 DXNo	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, atc.)	Blac	e - Amarica k, Whita, e :: Whita	etc.
Be Completed	(Specify only higher	t's Education st grade completed)		16a. Decedent's (Give kind of life. DO NO	Usual Occup If work done OT use retire	pation during most of wo	rking	16b. Kind of Bu	sinass/Ind	ustry
E	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Homem	aker			Hom	ie	
F O	17. Father's Nama (First, Middle,	Last)				18. Mother's Na	ma (First, Middle,	Maiden Surnam	a)	
TOB	Keller R. Kli	ne Sr.				Maude	H. Bear			
r traum	19a. Informant's Name/Relations Dennis L. Davis					and Number or Ru				Code)
any injury or other determine event, that page. To Be Com	20a. Method of Disposition 10 Burial 2 Cremation Donabon 5 Other (S	pecify)	CBI		cemete	ery Maye ess of Facility eral Home	, 1999 , 12525 B	20c. Location - Smiths b Bradbury ourg, Md.	wrg, N	Md.
be detected for use as the burist-transit by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or	as a consequence as a consequence as a consequence	of):				0	
Clan										-
Physician/	Part II. Other significant condition	was contributing to death	but not result	ing in the underly	ing cause giv	ven in Part I.	23b. Did to	1 -		the cause of de ably 4 Unk
Completed by	Corre	estur be	ent	feile	ul		24a. Was a perfor	med?	cor of c	re autopsy findir illable prior to npletion of cause leeth?
Be Com	25. Was case referred to make					26 Place of Do	1 ☐ Y		11	Yas 2□ No
To Be	axaminer?	Hospitat: 1 ☐ Inpa	tient 2 E	R/Outpatient 3E	DOA Ott	her /	loma 5□ Rasid	1	ar (Specify)
-	27. Manner Death Life and the Sign Pending 2 Accident investig	28a. Data of In (Month, E		28b. Tima of Injury	28c. Injui		28d. Describe h			
ž		not be	njury - At hom	na, farm, street, fa	ctory, office		28f. Location (S City or Tow		er or Rura	Route Number,
\$ 500 E	3 Suicide 6 Could detarm	ined 288. Place of t	etc. (Specify)							
5 5	4 Homicide detarm 29a. Certifier 1 Certifyin	ined 288. Place of t	t of my knowl	edge, death occu in and/or investiga	rred at the tir ation, in my o	me, date and place opinion, death occu	, end due to the corred at the time, d	ause(s) end ma late end place, a	inner es sta and due to	ated. tha cause(s)
To the Funeral Director: After completely filled in by the funer Medical Certification:	4 Homicide detarm	g Physician: To the bes Examiner: On the basis and manner:	t of my knowl	n and/or investiga	29c. Licens	opinion, death occu	erred at the time, o	late end place, a	(Month, L	tha cause(s)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant'a Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death **Physician** 1999 Nata Addis Kass 1:50 AM May /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County 16505 Virginia Avenue-Cottage 164 Williamsport If Under 1 Yaar Months Deys If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Feb. 8, 1916 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Hours 1 M 25€F 83 Yrs. Director 136-18-1492 New Jersey Usual Rasidanca of Dacedent death with the Manyland 10a. Stata 10b. County 10c, City, Town or Location show 10d. insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nutfied at Washington Co. Maryland Williamsport Director 1 ☐ Yas 2 🖾 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 16505 Virginia Avenue-Cottage 164 21795 USA Funeral 12. Was Decedent Ever In U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. filed within 72 hours efter 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Nevar Marriad 2 Married 21215-0020 1 ☐ Yas 2 ☑ No Specify: by White 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry lith end Mental Hygiene. 27 Is marked other than "r r traumatic event, the Wed Elementery/Secondery (0-12) College (1-4or 5+) 12 2 Secretary Broadcasting Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth jury or other traumatic even Be Roland V. Addis Dorothy Leland 19b. Meiling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21795 19a. intormant's Name/Ralationship (Type, Print) 16505 Virginia Ave.-Cottage 164, Williamsport, Frederic H. Kass, Jr./Husband 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 Crametion 3 ☐ Ramoval from State permit. Page Department of Important: If any injury or May 4 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Smithsburg Crematory 21. Signature of Funaral Sarvica Licansee 22. Name end Addrass of Facility Douglas A. Fiery Funeral HOme 1331 Eastern Blvd.N., Hagerstown, Maryland 21742 ceucles Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart dilura. List only one ceusa on each line. Approximata Intarval Batween Onsat and Deeth **Physiclan** /Medical Immediate Cause (Final disaasa or condition rasulting in daath) months Examiner Dua to (or as e consequance of): Examiner ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence ot): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 80 lor use P.O. signed by the a Pert II. Other eignificant conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Vee 2□ No 3 Probably 4 Unknown þ Division of Vital Records, The law requires 24b. Were eutopsy findings availabla prior to completion of causa of death? Completed 24a. Was an autopsy should page 2 s hes 2000 1 Yes 1 ☐ Yas 2 ☐ No or Attending Physician: funeral director, Be 25. Was casa referred to medical exeminer? 26. Piece of Deeth (Check only ona) Hospital: 1 | Inpatiant | 2 | ER/Outpatient | 3 | DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) Certification: To 1 Yas 2 No this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Affer 1 Matural 5 Pending invastigation 1 Yas 24 hours after death.

Funeral Director: A 2 No 2 Accident the 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) filled in by 4 ☐ Homicida Hospital 1 Certifying Physician: To the bast of my knowledga, death occurred at tha tima, date and place, and dua to the causa(s) and manner es statad.

2 Medical Exeminer: On the basts of axamination and/or invastigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and manner statad. 29a. Cartifiar Medical (Check only within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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32. Régistrar's Signatura

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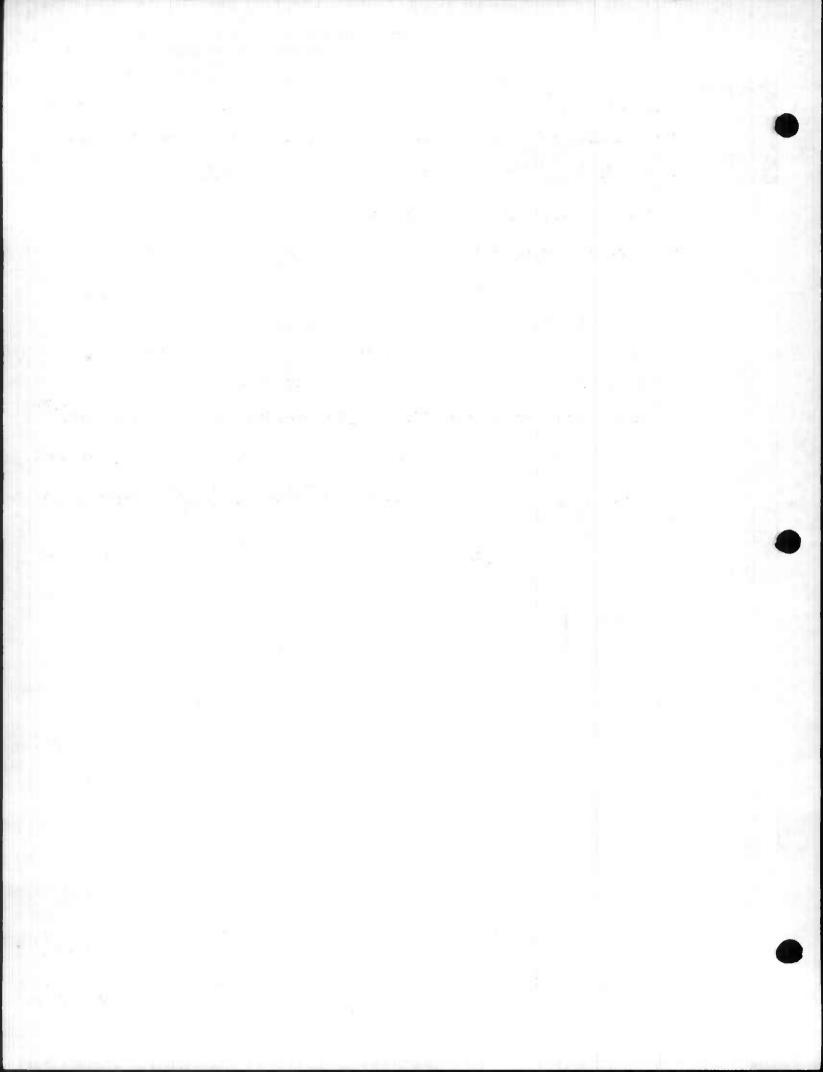
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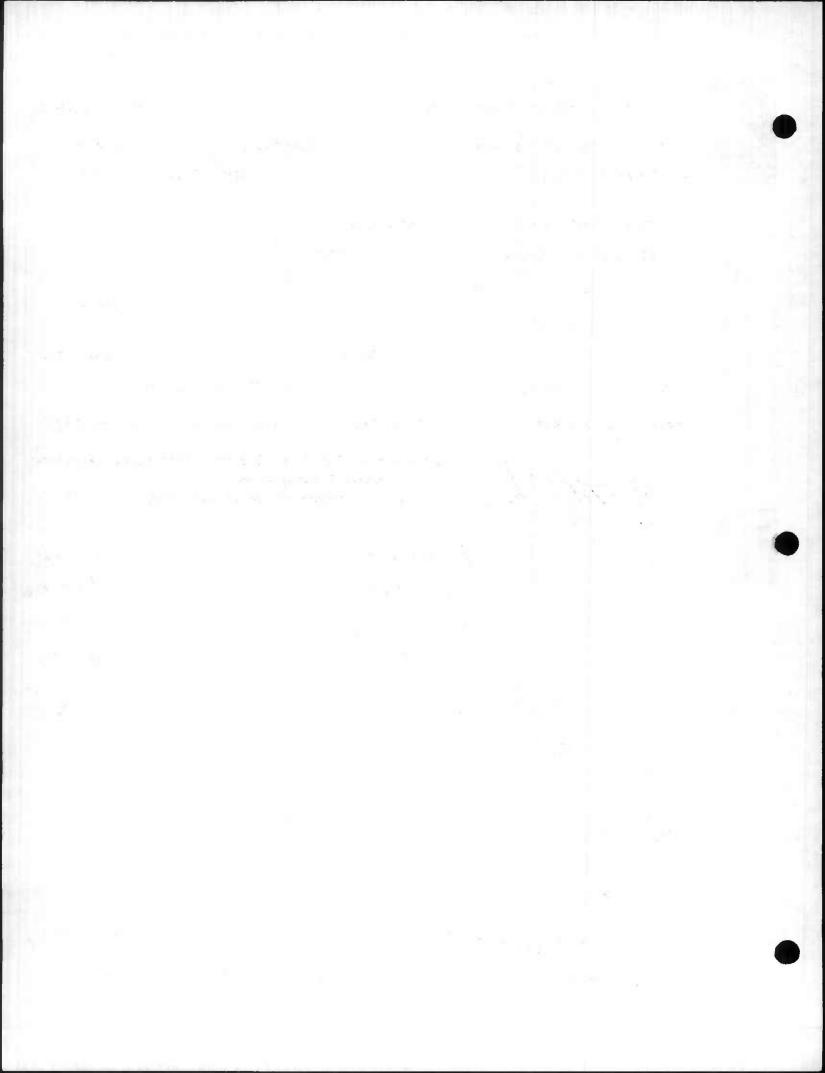
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nent of Health and Mental	Hygiene	0	1		7	-7	ř

MATTHEW	LU	IPERSBECK	State of M	iaryiand /		tificate of	Death	mental Hy	/giene Reg. No.) [5775
Physi	cian	1. Decedent'a Name (First, Middle, La Matthew Justin I		17				2. Date of D		O Year	3. Time of Death
/Med Exam	dical	4a Facility Name (If not institution, gi	ve street and number,)			4b. City, Town, or			1999 Thy of Death	0105 AM
- LAUIT		18800 ROXBURY RO					HAGERST			HINGTO	
Funera Directo			. 57	ge (In yrs. last l	Yrs.	Months Deys	If Under 24 Hrs Hours Min.	(Month, D	irth ey, Year) , 1981	9. Birthp Cour Penr	place (State or Foreign ntry) nsylvania
how		10a. State 10b. County		10c. City, To	wn or Loc	ation				1	10d. Inside City Limits
he Me	octo	W. Va. Berkel	.ey	Fal	ling	Waters			10- 02:	4 14 Page 4 Comm	1 ☐ Yes 2 🖔 No
death with the Marylend ms 23e or 28e-f ahow	i Dir	507 Lady Diane Co	urt			25419			10g. Citizen o		mry /
5 £ 2	by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2X If Yes, Give Year or Dates:	?	lf.	las Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specity:	Specify Yes or N to Rican, etc.)		ace - Americ lack, White,	
Maryland 21215-0020 d 2 should be filed within 72 hours aft in and Meniel Hygiene. 7 is marked other than "natural", or traumatic evant, its Medical Exerci-	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	(Give k	ent's Usual Occup	during most of wo	rking	16b. Kind of	Business/In	dustry
within then	Jdmo	Elementary/Secondary (0-12)	College (1-4or	5+)	nor	<i>0 NOT</i> u <i>se retired</i> 1e	1)			none	
nd High	BeC	17. Father's Name (First, Middle, Las					18. Mother's Ne	me (First, Middle	e, Maiden Sume	eme)	
Vial ould b Mented	To E	Michael Anthony						Frances			
Mar d 2 sh d 2 s	-17	19a. Informant'a Name/Relationship					and Number or R			IIIA	
re, Hem 2		Kathy F. Luipers 20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other place	ne Ct.,	Date	20c. Location		
Imore, Peges 1 ar nent of Heam ant: If Heam ury or other		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci				en Cemet		5-1-99	Hagers	town,	Md.
Balti Pemit. Departm Importa		21. Signature of Funeral Service Lice	nsee	me	1	Name and Addre	ss of Facility M	INNICH ., Hage			21740
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	iplications that cause one cause on each	d the deeth. Do	o not enter	r the mode of dyir	ng, such es cardia	c or respiretory	errest,	1	Approximete Interval Between
Physician /Medica		Immediate Cause (Final		111	(1)	10				į	Onset and Death
Examine		disease or condition resulting in death)	a1	Due to (or as	911	1000000			-	1	
D =	iner			Due to (or as	a consequ	ierioe org.				1	
and al-trans	xam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	Due to (or as	e consequ	ence of):					
x 68760, ertificate be executed sing physician and se as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as e	consequ	enca of):					
Cords, P.O. Box (requires that the death certif been signed by the attending ahould be detached for use a	Physician/M	Part II. Other significant conditions of	contribution to death I	out not reculting	in the up	torbino couso six	on in Part I	23h Dio	I tobacco use	ontribute t	o the cause of death?
P.O.	Phys	ratii. One agiinean conditors	Antibuting to death t	out not resulting	in the one	derlying cause gre	en in raiti.		Yes 2 No		bably 4 Unknown
To the the the the the the the the the the	by									T 14	4
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Ital	BeC	25. Wes case referred to medical examiner?					26. Place of De	ath (Check only	7		<u></u>
Physic stilling at dire	2	Yes 2 No 27. Manner of Death	Hospital:		-		4 LI Nursing I	T			AT SCENE
DIVISION Of VITAI or Attanding Physicien: 1 after death. Director: After this certifica d in by the funeral director, p	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Dete of Inju (Month, Da 4-28-	ay Year)	Time of Injury	28c. Injur Wor M 1□	Yes 20 No	Subbac	t Varae	1.10	in (a)
VISI Attan	tiffice	Suicide 6 Could not be determined	28e. Place of In			et, factory, office		28f. Location	-	mber or Run	ai Route Number,
Parage III				۔ د)AiL			18800 k	Roxbury	Rd	21746
DIVISION Of VITAI Re to the Hospital or Attanding Physician: The k within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical		nysician: To the best miner: On the basis o and manner st	of examination a							
To the To the compl	Me	29b. Signature and title of certifier	/ ,		^	29c. Licens			29d. Date sign		
		1 Strat	orhe	1hr	D	0.0	C.M.E		APRII	L 28,	1999
		WARON U	completed cause of	1111			Baltimo	re, Mary	yland 2	1201	
S Regis	tate trar	31. Date filed (Month, Day, Year) MAY 0 4 19		rar's Signature	G.	Space					

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				State of Maryla	-	ertificate of		mental Hy	/giene () (Reg. No.		5776	
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Dete of De Month	eath Dey	Year	3. Time of Deeth	
J	/Medic	al	Charles Frank		Sr.			April	29 1	999	5:06 am	
ı	Examir	er	4e. Fecility Neme (If not institution, give				4b. City, Town, or					
Н	Funeral		Avalon Manor Nu 5. Sociel Security Number 6.5	rsing Home Sex 7. Age (In yi	s. lest birthdey	() If Under 1 Year			rth	9. Birtho	ngton lece (Stete or Foreign try)	n
	Director		214-28-2227	7. Age (In yi	Yrs.	Months Days	Hours Min.	(Month, D.	13,1931	Coun	ryland	
	pu *		Usuel Residence of Decedent 10e. Stete 10b. County	100	City, Town or L	anation						
	Aaryla f sho	ō	,		•					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	28a	Director	Maryland Washin 10e. Street and Number	gTon	Hager	-stown 10f. Zip Code			10g. Citizen of V	Vhet Coun	itry?	_
	h with	a D	11912 Robinwood	Drive		217	42		USA		.,,	
	deat	Funeral	11. Maritel Status	12. Was Decedent Ever In Armed Forces?	U,S. 13.	. Wes Decedent of I		Specify Yes or N		e - Americ		
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mantal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, the Medical Example must be notified at	by Fu	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2XXNo If Yes, Give Year or Detes:		1□ Yes 21 No		to Fican, etc.)	Specify	k, White,		
9-	2 hou		15. Decedent's E	ducation	16e. Dece	edent's Usuel Occur	petion		16b. Kind of Bu		ite	_
215	thin 7:	Completed	(Specify only highest green Elementery/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	edent's Usuel Occuj e <i>kind of work don</i> e <i>DO NOT</i> use <i>retire</i>	during most of wo	rking				
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re,	of Heal		20a. Method of Disposition	20b		position (Neme of emetory or other ple		Date	20c. Location -			
Ē	Pages nent of h ant: If he ury or of		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetlon 5 ☐ Other (Specific	Hellionel Holli State		n Memoria	1	5-3-99	Williams	port	,Maryland	
Baltimore, Maryland 21215-0020	permit. Page Department of Important: If any Injury on once.		21. Signature of Funeral Service Licer			Sporne and Add						Т
ш	205 20		11/93/11/	11-	42	25 S. Cond	ococheagi	ue St.Wi	lliamspo	rt, M	D 21795	
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plicetions thet caused the de one ceuse on each line.	eth. Do not er	nter the mode of dyi	ng, such as cardia	c or respiretory	errest,		Approximete Intervel Between	
	Physician /Medical		Immediate Cause (Final	D						!	Onset and Deeth	
	Examiner		disease or condition resulting In deeth)	e. /n	(or as e conse	nig				14	t weeks	
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68760,	ificata g phys as the	edical	thet initieted events resulting in death) Lest		(or es a conse							
Box	nding use a	M		d	roke					1	4 years	
	death	sicia	Pert II. Other algorificant conditions of	ontributing to death but not re	esulting in the	underlying cause gir	ven in Pert I.	23b. Did	tobacco use cor	ntribute to	the causs of death?	?
О. О.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	1			, ,			Yss 2□ No	3 Prot		
ds,	iras the signed of bed bed	d by	7770-17					0.4-1111-1		0.45 144	ere eutopsy findings	
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Be	he law a has age 2	ошо	Or					10	Yes 2 No		deeth?	
ta		Be C	25. Wes case referred to medical				26 Place of De	eth (Check only		11	Yes 2 No	
>	Physician: The la this certificate has ral director, page 2	To	examiner? 1 ☐ Yes 25 No	Hospitel: 1 Inpatient 2	☐ ER/Outpetie	ent 3 DOA Ott			Idence 6 Oth	er (Specify	()	ī
0 0	ng Phy tter this		27. Menner of Deeth 1 Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	of 28c. Inju			how injury occurr			
Sio	teath. tor: A the f	cat	2 Accident Investigation 3 Suicide 6 Could not b				Yes 2 □ No					
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completaly filled in by the funeral phases.	Certification:	4 Homicide determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, st cify)	treet, factory, office		28f. Location City or To	(Street end Numb wn, Stete)	er or Rure	I Route Number,	
	spital hours neral y fillec		29a. Certifier 1 Certifying Ph	ysician: To the best of my ki	nowledge, deel	th occurred et the ti	me, dete end place	e, end due to the	ceuse(s) end me	nner as st	eted.	
	the Holin 24 the Fu	edical	(Check only 2 Medical Examone)	nnar: On the basis of exemi	netion end/or in	nvestigation, in my o	pinion, death occu	irred et the time,	date end place,	and due to	the ceuse(s)	
	To	Σ	29b. Signature end title of certifier	13		29c. Licens	se number		29d. Dete signed	(Month,	Dey, Yeer)	,
		}	00 No.	1		ע.	77779		ATISCE	, 2	1, 1771	
			30. Name and address of person who ZAFAR MAZIK	completed cause of deeth (Its	CAPP	ANS RI) BOONS	BORD	MO.	2/7/	Dey, Yeer) 9, 1999 13.	
	Sta	_	31. Dete filed (Month, Dey, Year) APR 3 0 19	32. Repistrer's Sig	nature &	Ann 1	41					-
	Registra	ar	HLU 5 A 19	JJ /	/	Lot rate						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Enid VanderHave Lardizabal na /Medical 46. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Washington County Hospital Washington County Hagerstown If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) May 29, 19 Birthplece (State or Foreign Country) 5. Sociel Security Number **Euneral** 1 M 2 XF 65 Yrs. 149-26-3123 1933 Director New Jersey Usual Residence of Decedent the Meryland 10c. City, Town or Location 10d. Insida City Limits 10b. County r than "natural", or items 23s or 28s-f show tre Madical Examiner naut be notified at 1 ☐ Yes 2 1 No Maryland Washington Co. Hagerstown Director 10g. Citizen of Whet Country? 10f. Zip Code 10e Street and Number deeth with 13302 Unger Road 21742 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 11. Maritel Stetus filed within 72 hours after 1 ☐ Yes 2 ☑No 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 specify: White p Year or Detes: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elemantery/Secondary (0-12) College (1-4or 5+) Doctor's Office Bookkeeper 12 marked other 18. Mothar's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be it of Health and Mental Mary Lapchak T. John VanderHave 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 13302 Unger Road, Hagerstown, Maryland 21742 19e. Informent's Name/Ralationship (Type, Print) Dr. Evaristo R. Lardizabal/Hus. 20b. Plece of Disposition (Neme of cematary, crametory or other plece) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition 1 XBurial 2 Cremetion 3 Removel from State permit. Pege Department o Important: If Lodi, New Jersey Lodi Cemetery May 7 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funerel Service Licensee 1331 Eastern Blvd.N., Hagerstown, Maryland 21742 Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or head feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immadiata Causa (Final disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaese or Injury that Initiated evants resulting in death) Last and ettending physiclan for use as the burie Box 68760, requires that the death certificete be Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the the signed by t 1 Ves 2 No 3 Probably 4 Unknown Division of Vital Records, P. þ 24b. Wera autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy peen : has 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 12 No 1 Inpatiant 2 PER/Outpatient 3 DOA Certification: To this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred After Attending 1 Naturel 5 Pending invastigation Injury 1 ☐ Yas 2 ☐ No death. 2 Accident efter death Director: / 6 Could not be n 24 hours efter de he Funeral Directo pletely filled in by th 3 Suicide 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital or 1 Cartifying Physician: To the best of my knowledge, daath occurred at tha tima, data and piece, end due to the cause(s) and mannar as steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. edical 29a. Certifier within 2 29d. Date signed (Month. Dev. Year) 29b. Signeture end title of certifier 29c. License number

Registrar

30. Name end addrass of

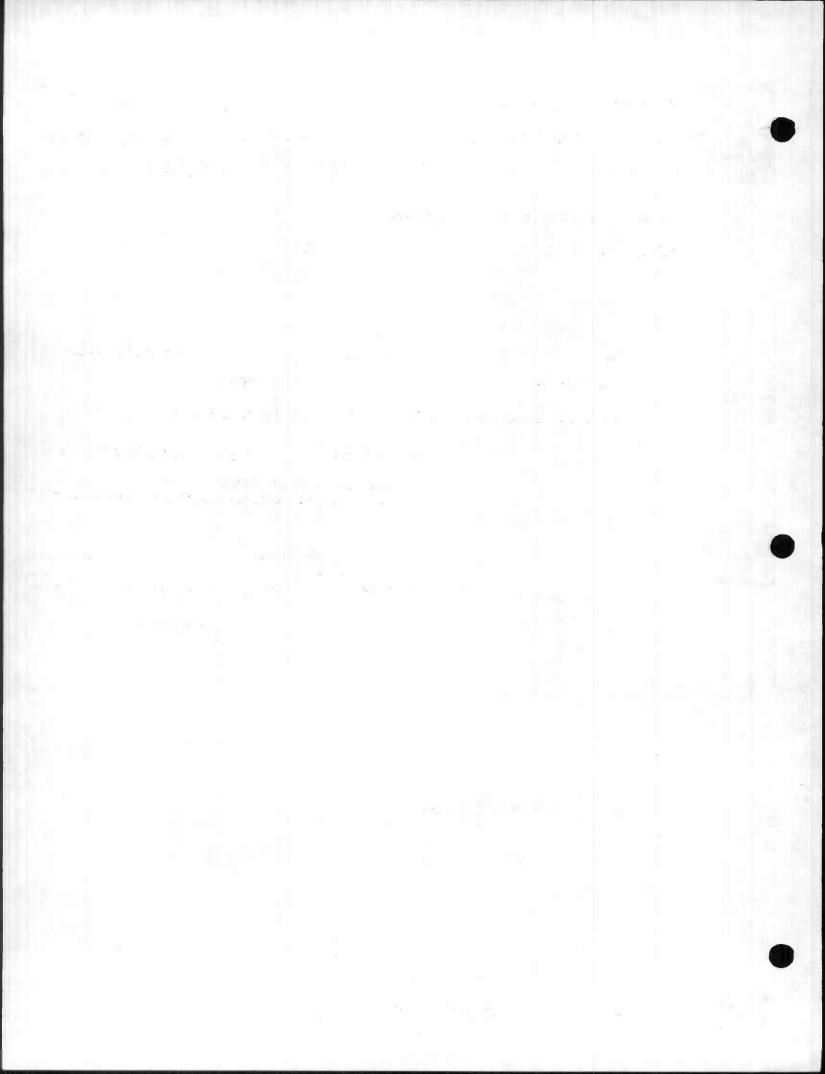
31. Data filed (Month, Day, Year)

32. Registrer's Signeture

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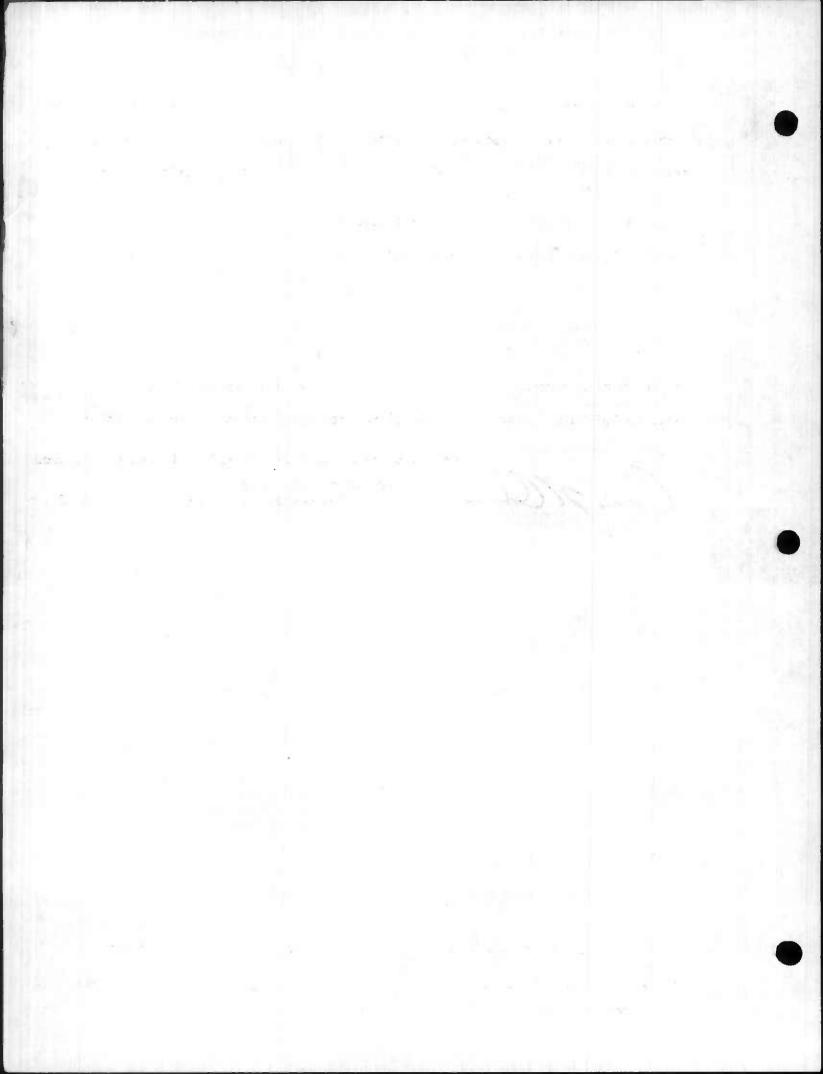
person who completed cause of deeth (Itam 23a), (Type, Print)

0 6 1999 DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici		1. Decedent's Nama (First, Middle, La	ist)		Certificate of		2. Deta of Dea	Reg. No. ath		3. Time of Death
		Helen Hershey	Miller				Month May		999	9:00 AM
/Media		4a. Fecliity Neme (If not institution, give				4b. City, Town, or				10.014
		16505 Virginia Av	venue Hillt	op Apt	. B219	Williams	port	Was	hingto	on
Funeral Director		5. Social Security Number 6. S 220-46-1704 Usuel Residence of Decedent	Sex 7. Aga 1□ M 2□XF	(In yrs. last bit	Yrs. If Under 1 Ya Monihs De			, 1910	9. Birthpla Country Mar	ce (State or Foreign y) y I and
items 23a or 28a-f show ther must be northed at	_	10a. Stete 10b. County		10c. City, Tow	n or Location				100	d. Inside City Limits
Parity State	Director	Maryland Washi	ngton	W	illiamspor					
200		10e. Street end Number		A - 4	10f. Zip Cod			10g. Citizen of V		y?
s 23	erai	16505 Virginia Av	12. Was Decedent E			1795	Specify Ven or No	US 14 Bac	e - Americar	a Indian
el', or	by Funeral	1 Never Married 2 Marriad 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yas, specify C	of Hispenic Origin? (S suban, Maxican, Puer No <i>Specify:</i>	to Rican, etc.)	Biac Specify	k, White, at	c.
"natu	Completed	15. Decedent's E (Specify only highest gre	ducation ede completed)	16e	Decedent's Usuel Oc (Give kind of work do life. DO NOT use rel	ne during most of wo	rking	16b. Kind of Bu	ısiness/Indu	stry
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it,	BeC	17. Fether's Neme (First, Middle, Lest)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ma (First, Middle,			
	ToB	Roger Charles Hei	shey			Violet	Florence	e Meyer	S	
W W @		19e. Informent's Neme/Reletionship (o. Mailing Address (Str. 0325 Walth:					
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20		1 ☑ Burial 2 ☐ Cremation 3 ☐			f Disposition (Name of ry, cremetory or other					
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DHMH 16 Rev 6/95

Registrar

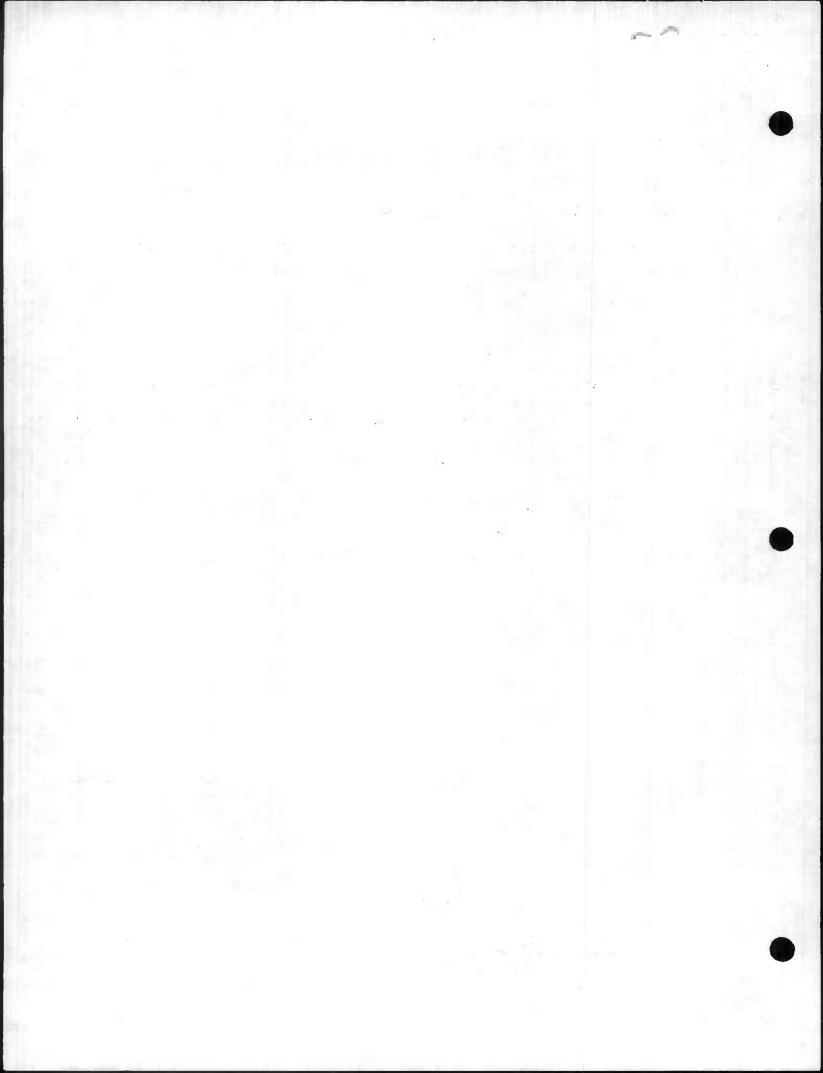
31. Date filed (Month, Day, Year)

MAY

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4 1999

32. Registrar's Signature



99-2514-033

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

GARY MCGOWAN I	TEMS: #23 PART I, 2		daryland / Dep 0 6771 Ce	ertificate of	Death			,	720
Physician /Medical	1. Decedent's Name (First, Mic Gary Paul Mo					2. Date of Dea Month MAY	Day	Year 199	3. Time of Death 1:47P.M.
Funeral Director	4a Facility Nama (If not institut 671.8 FOSTER ST 5. Social Security Number 212 66 7275	REET	r) Age (In yrs. last birthda) 44 Yrs.				PRINCE	GEO1	RGES lace (State or Foreign)
dand mg m	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Town or L	Location				10	0d. Insida City Limits
e Maryla e-f show iffied at	MD P.	G.	Distr	ict Heigh	nts				1 ☐ Yes PNo
ith with the Maryland 23e or 28e-f show ust be notified at rel Director	10e. Street and Number 6505 Halleck	Street		10f. Zip Code 20747	7		10g. Citizen of W United		
d within 72 hours after death vigines. giene, re than 'natural', or thems 23s, the Medical Examiner must. Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorce	If Yes Give	iXio	. Was Decedent of If Yas, specify Cul 1 ☐ Yas 2XXIII	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yas or No- o Rican, atc.)		e - Amarica k, Whita, a Wh	
ed within 72 ho ygiens. ser than "neturn r, the Medical. Completed		ent's Education est grade completed) College (1-4o	(Giv life.	edent's Usual Occur te kind of work done DO NOT use retin	during most of wor ad)	king	16b. Kind of Bu	sinass/Ind	
d 2 should be flied th and Mental Hyg 7 is marked other traumatic event, To Be C	17. Father's Nama (First, Middle Paul Alan McC				18. Mother's Nar	me (First, Middle, lizabeth		e)	,
od 2 sho lith and 27 is my r traum	19e. tnformant's Neme/Reletio Paul A. McGowa		19b. Mei 8412	ling Address (Street Thornbe	or and Number or Rucry Drive	East, U	or, City or Town, pper Mai	State, Zip rlbor	Code) O, MD 2077
ermit. Pages 1 a Bepartment of Hei mportant: If Item iny Injury or othe abox.	20a. Mathod of Disposition 1XX gurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other			ematory or other pla	ery May 7	Data , 1999	20c. Location - Suitlar		wn, Stata iaryland
permit. P. Departme Important any injury abbs.	21. Signature of Furterni Sept	o Lidensee			ess of Facility Les a Ferry R				
Hillicate be executed physician and as the burden-fransit as the b	Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. NARCOTI	C AND ALCOHOL Due to (or as a conse Due to (or es a conse Due to (or as a conse	equence of):	ION				
es that the death certifling igned by the attending to be detached for use as by Physician/Me	Part II. Other significant condi	d.	but not resulting in tha	underlying cause g	iven in Pert I.				the cause of death?
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an: The law rifficate has stor, page 2						1 🔄	as 2 No	1	Yas 2 No
clan: entitle ector	25. Was case referred to medic examiner?	Hospital:		10	thor	eth (Check only o			
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# # # E	4 Homicide deter	mined 286. Place of a building, of FOUN	njury - At homa, farm, s atc. <i>(Specify)</i> ID IN YARD t of my knowledge, dea	ith occurred at the t	ime, date end place	HEIGHTS,	causa(s) and ma	nnar as st	ated.
within 24 hosp within 24 hos To the Fune completely fi	one)	Examiner: On the basis and manner s	of axamination and/or intated.						
To the comple	29b. Signature and title of certif	Melkul	ا	0.	C.M.E.		1AY 3,19		Day, Year)
Jr 10	30. Name and address of personal Company of the Com	m Kon	death (Item 23a) (Type		n Street,	Baltimo	ore, Mar	yland	1 21201
State Registrar	MAY 1	3 1999		6-					

DHMH 16 Rev 6/95

Mar 1 5 550 Some to Special

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Cen	ificate of	Death		Reg. No.		2731
	1. Decedant'a Nam	ne (First, Middle, Las	st)	1,	- 4 /			2. Date of De Month	ath Day	Year	3. Time of Death
Physician /Medical	EL	-LA		NO	EAL			April		999	1:15 AM
Examiner		If not institution, give HEALTH			THERN	MD	4b. City, Town, or Clinton		4c. County Prince		e's
uneral rector	5. Social Security 1 578–28–445 Usual Residence of	2	ax 7. A □ M 2및 F	ga (In yrs. I	ast birthday) Yrs.	If Under 1 Yaa Montha Day					placa (Stata or Foreign place) bia, SC
or set at	10a. State	10b. County		10c. City	y, Town or Loca	ation				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
river must be notified.	Maryland 10e. Street and Nu	Prince Geor	rge's	Clint	ton	10f. Zlp Code			10g. Citizen of	What Cour	
la la	9211 Stua	rt Lane				2073			U.S.A.		
b E	3 Widowed	ried 2 Married	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Datas	? No	lf '	as Decedent of Yes, specify Cu □ Yes 2√2 N	Hispanic Origin? (! lban, Mexican, Pual o Specify:	Specify Yes or No rto Rican, etc.)		ck, White,	etc.
rt, tre Matrial Ex Completed by	(Spe	15. Decedant's Ed	lucetion de complated) College (1-4or	5+)	(Give ki	ent's Usual Occ ind of work don O NOT use reti	e during most of wo	orking	16b. Kind of B	usiness/in	dustry
Com	8				Dames	stic Work	1		Priva	-	
Be se	17. Father's Name	(First, Middle, Last)						ame (First, Middle, Chatman	, Maiden Surnan	ne)	
traumatic		s Gladden ame/Raletionship (1	Tune Print)	-	10h Malling	Addrage /Stra	et and Number or F		er City or Town	State 7in	Code
5	Keith T. N		, ypo, 1 mm,				Street #14				
É	20a. Mathod of Dis	position ☐ Cramation 3 ☐		0.0	lace of Disposi		/ace)	Date	20c. Location	- City or To	own, State
any Injury or		5 ☐ Other (Specify uneral Service Licen		Ceda	r Hill C	emetery Name and Add		5/1/99	Suitland,	MD	
any ir	12)	4/4		Cex	dar Hill	Funeral Ho Ivania Aven	me, Inc.			
cian dical niner	23a. Part1. Entar shock, or had limmediate Causa disease or condition resulting in death)		icat ons that cause ona dusa on each a. EN	5	n. Do not enter	r the mode of d	ying, such as cardle	ac or respiratory a	rrest,		Approximata interval Between Onset and Death
# 5	1					anca ory.					
· ×	Sequentially list or if any, leading to ir cause. Enter Und Cause (Disease or that Initiated event rasulting in death)	5	b		r as a conseque	ance of):					
e es the bur	rasulting in daath)	Last	b	Due to (or	as a conseque	ence of):					
Medical	rasulting in daath)	5	cd	Due to (or	as a conseque	ence of):	givan in Part I.		tobacco uss co Yss 21 No	entribute to	o the cause of death? bably 4 □ Unknow
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entricata has been signed by the attending physicia scorp, page 2 should be detached for use as the but Be Completed by Physician/Medical	rasulting in daath)	ficant conditions or	Hoenital:	Due to (or	as a conseque	ence of): ence of): derlying ceuse	26. Place of De	1 □ 24a. Was perfo	an eutopay med? Yes 2 No	3 Pro 24b. W av cc of	bably 4 Unknow era autopay findings allabla prior to mpletion of ceuse death? Yes 2 No
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DHMH 16 Rsv 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Ethel Grace Ott 4.50 PM 30 HOCH 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) Washington County Hospital Washington County Hagerstown If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) May 3, 1916 Birthplece (State or Foreign Country) 1 M 2 XF Months Deys Hours 82 Yrs. 380-32-6464 Canada Usual Residence of Decedent 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits 1⊠ Yes 2 No Maryland Washington County Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 268 South Potomac Street 21740 Canada Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Raca - American Indien, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Merried White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 0 Housecleaner Private Homes 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Richard Ott Florence Blake 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Doris L. Moser/Friend 77 Sunbrook Lane, Hagerstown, Maryland 21742 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Rest Haven Cemetery May 4 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 ceciplo Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat/failure. List only one cause on each line. Approximete Interval Between Onset end Deeth immediate Cause (Final disease or condition resulting in deeth) days Heursphie Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown te represdid Inforction 24b. Were eutopsy findings available prior to Completed 24e. Wes en autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1/2 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nearl of Heath and Mental Hygiene.
In: If Itam 27 is marked other than "natural", or Itams 23.
Ity or other traumatic event, the Medical Engine mental rry or other traumatic event, the Medical Engine or mail

Baltimore, Maryland 21215-0020

the Maryland

ician and burial-transit physician s the burial d for use as t signed t

Examiner

Physician/Medical

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Certification:

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1 Neturel

2 Accident 3 Suicide

4 🗌 Homicide

GLORIA

29e. Certifier

page 2 funeral director,

A 24 hou. To the Hospi within 24 hou To the Funer completely fil

> State Registrar

31. Dete tiled (Month, Dey, Year)

29b. Signature and title of cartifier

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d, Date signed (Month, Dev. Year)

30 Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) WRA

MULL ST

HAGERSTOWN MQ 21200

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

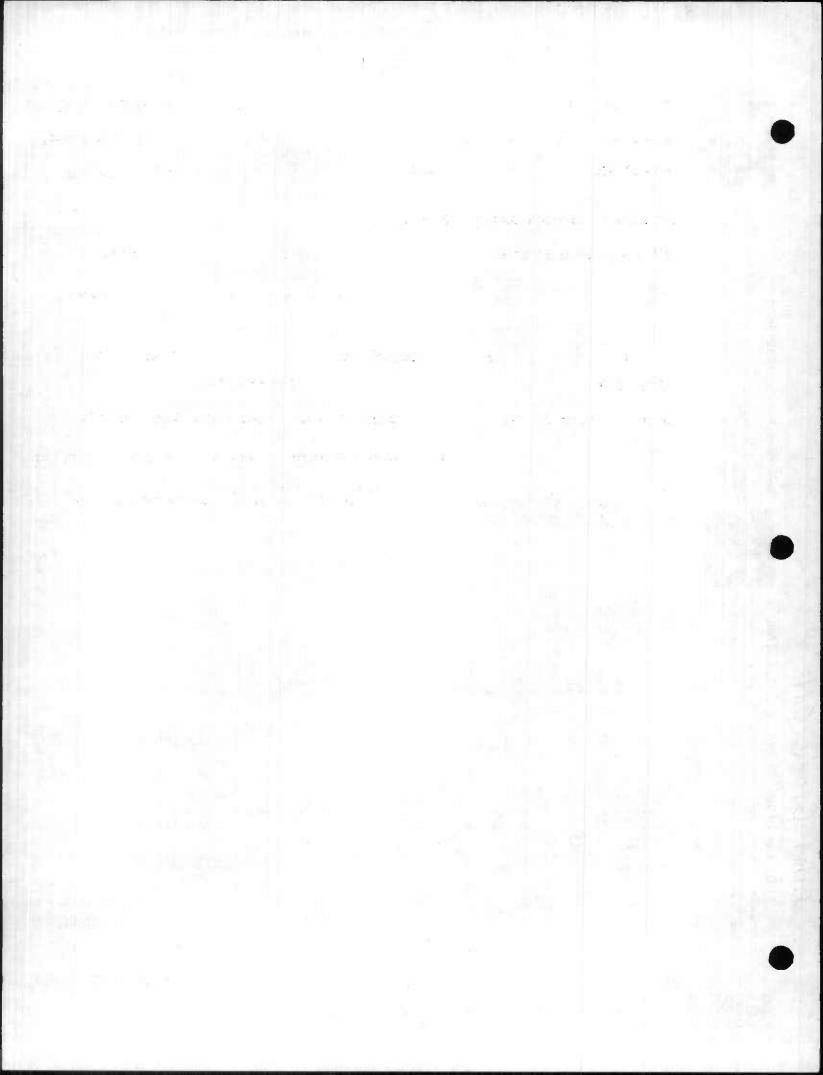
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5 Pending investigation

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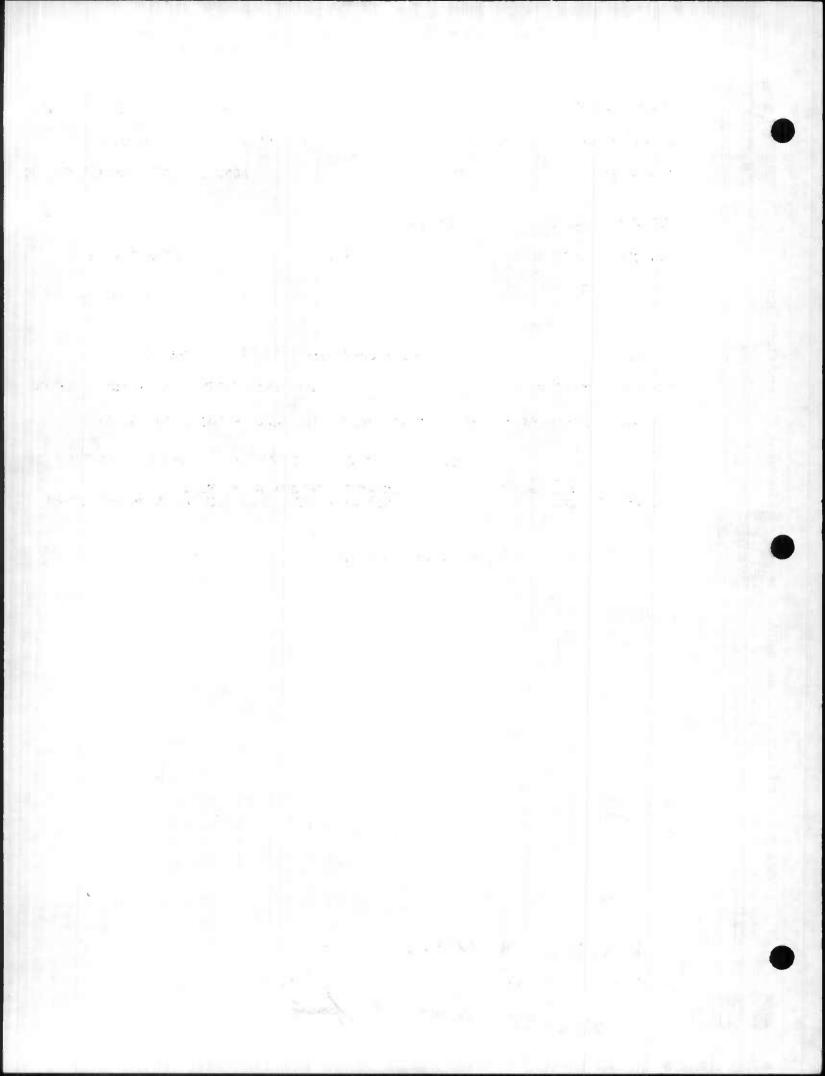
32. Registrer's Signeture



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

			(Certificate of	Death		Reg. No.	9 15	783
Physician /Medical	1. Decedant's Name (First, Middle, L JAMES LESTER					2. Data of Do Month MAY	Day	Yaar	Tima of Death 5:44PM
Examiner	4a Facility Nama (If not institution, g 9945 BUNKER I				4b. City, Town, or WALDOI		- 1	of Death	
Funeral Director	5. Social Sacurity Number 6. 218-30-2522	Sex 7. Aga (In yrs. last birth	day) if Undar 1 Yaar Months Days			rth ay, Year)	9. Birthplaca Country)	(Stata or Foraig
dand mand	Usual Residence of Decedant 10a. Stata 10b. County	1	0c. City, Town	or Location				10d. l	nside City Limits
a-f sh	MARYLAND CHARLES	3	WALDORF					1	☐ Yas 2 No
or 28	10e. Street and Number			10f. Zip Coda			10g. Citizen of V	Vhat Country?	
a 23a	9945 BUNKER HILL	_		20603			UNITED		
al; or items 23s or 28s-1s Examinet must be northle by Funeral Director	11. Marital Status 1 □ Naver Marriad 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Even Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give Yaar or Datas:	er in U,S.	13. Was Dacedant of H If Yas, specify Cub 1 ☐ Yas 2 ☒ No	an, Maxicen, Puarl	o Ricen, atc.)	Specify	e - Amarican fr ck, Whita, atc.	
th and Mantal hygiens. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Medical Evanther must be notified at traumatic event, its Medical Evanther must be notified at traumatic event, its Medical Evanther must be inclined at the completed by Funeral Director.	15. Decedent's (Specify only highast g Elementary/Secondary (0-12) 8th			Decedent's Usual Occup Giva kind of work dona lifa. DO NOT usa ratire DER OPERATO	during most of wor d)		16b. Kind of Bu	usinass/Industr	у
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Mente arked	JOHN OSCAR PROCT				ELIZABET				
le m	19e. Informent's Name/Reletionship			Meiling Address (Straat					(e)
Health sm 27 rther tr	CATHERINE A. PRO 20a. Method of Disposition			45 BUNKER H	ILL KOAD	Date Date	RF, MD	20603	State
nent of ant: If it ury or o	1 XBurial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec	□Removal from State ify)	cematary	EPH'S CHUR	CH CEMET	5/7/99	POMFRET		
Departi Importi any inj phos.	21. Signatura of Funaral Service Licon THORNTON		- 35-	22. Nama and Addre THORNTON F 3439 LIVIN	UNERAL H	AD IND	LAN HEAD	, MD 2	20640
e ettending physician and proposed as the bunel-transit and proposed as th	23a. Part1. Entar tha diseasa, or conshock, or heart failura. List only Immediata Causa (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceusa. Entar Undartying	a. PANCI	REATIC	CANCER onsequence of):				One	set and Death
= 0	ceusa. Enter Underlying Causa (Disaasa or Injury thet initiated events resulting in death) Last	c	a to (or as a co	nsequance of):					
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Pege C						10	Yas XX No	1 □ Ya	s 2 No
this certific rel director, To Be	25. Was cesa rafarrad to medicel axaminar?	Hospital:		_ 0"	26. Place of Da				
reldin	1 ☐ Yas 2XX o	1 LI Inpatient		batient 3LI DOA	4 LI Nursing F		how Injury occur		
within 24 hours effer death. To the Funeral Director. Affer t completely filled in by the funer Medical Certification:	XXNatural 2 Accidant 3 Suicida 4 Homicida 5 Panding invastigati 6 Could not detarmine	be One Place of Injury	- At homa, fari	ury Wo	rk? Yas 2⊡No	28f. Location	(Street and Numb		ute Number,
n 24 hours e he Funeral D pletely filled i		hysician: To the best of r iminer: On the basis of ax	camination and						
within To the comple	29b. Signatura and titla of certifiar	and mannar states	Om	29c. Licans	se number		29d. Date signe MAY 4		
	30. Nama and addrass of person who				A PLATA	, MD	20646		
State	01 0 1 00 1 00 1 0 1 1	167		B. Spi					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day 14 Leonard Thomas Reese 12 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, give street end number) Washington County Hospital Security Number 6. Sex 7. Age (in yrs. last birthday) Hagerstown If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Year) Washington 9 Birmplace (Stete or Foreign Country) If Under 1 Year 5. Social Security Number 100 M 2□ F Months Deys 225 16 1464 8/18/21 Va. Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2□No Md. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Counfry? 344 Henry St. 21740 USA 12. Wes Decedent Ever in U,S. Armed Forcaa? 1 ☐ Yes 2 ☐No If Yas, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Merried Merried 1 Yas 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 10th. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17 Fether's Neme (First Middle Last) Joe Willie Reese Josie Reese 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 344 Henry St. Hagerstown, Md.21740 Betty L. Reese 20b. Plece of Disposition (Nema of cemetary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 5/7/99 Hagerstown, Md. Rose Hill Cemetery 21. Signeture of Funerel Service Ligensee 22. Name end Address of Facility Watsons Funeral Home als 23a. Pert1. Enter the disaasa, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Interval Between Onset end Deeth MEGACOLON Immediata Causa (Final 2. Yhous diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Diseasa or Injury that initiated events reaulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? VARUALT 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performad? complation of cause of death? 1 ☐ Yes 2 ☐ No 25. Wea cesa raferred to medical 26. Placa of Daath (Chack only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No spital: 1 Inpatienf 2 28a. Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28b. Time of 28c. Injury af Work? 28d. Describe how Injury occurred 5 Pending 1 Yea 2 No

Physician /Medical Examiner

Examiner

Physician

Examiner

Funeral

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be re-

permit. Pages 1 and 2 should be filed within 72 hours after death a Important: If fem 27 is marked other than 'natural', or Items 23s any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

Director

Funeral

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/Medical

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certificate this

requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medicai Completed Hospital or Attending Physician: Be 0 funeral Certification: efter death. Director: After t

> State Registrar

filled in by

Medical

24 hours e

To the Hosp within 24 ho To the Fune completely fi

6 Could not be datarmined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homleida 29a. Certifian 1 Certifying Physician: To tha best of my knowledga, death occurred et the time, dete and plece, end due to the ceuse(a) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner steted.

29b. Signature and title of certifier

Investigation

29c. License number

29d. Dafe signed (Month, Day, Year) H865

causa of daath (Item 23a) (Type, Print) 30. Nama and eddress of person who complated

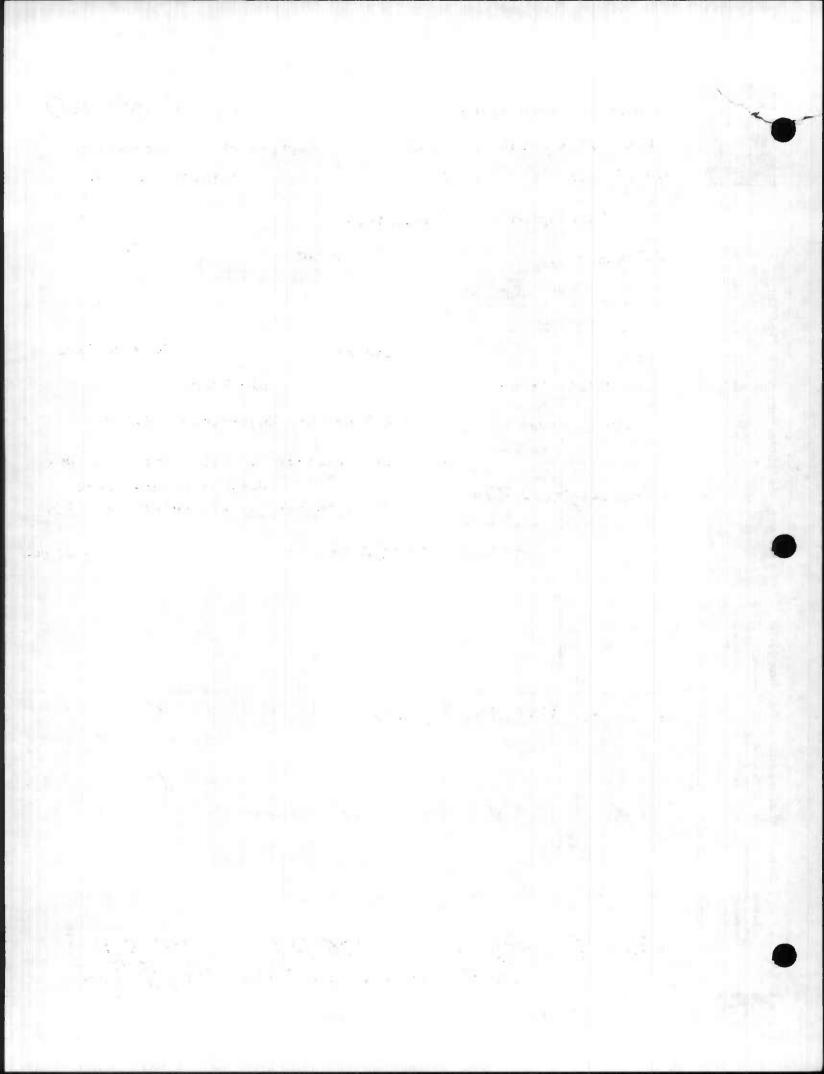
ANNAM DEL 1110

31. Dete filed (Month, Dey, Year) MAY 0 5 1999

2 Accident

3 Suicide

32. Registrer's Signature



Piease Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

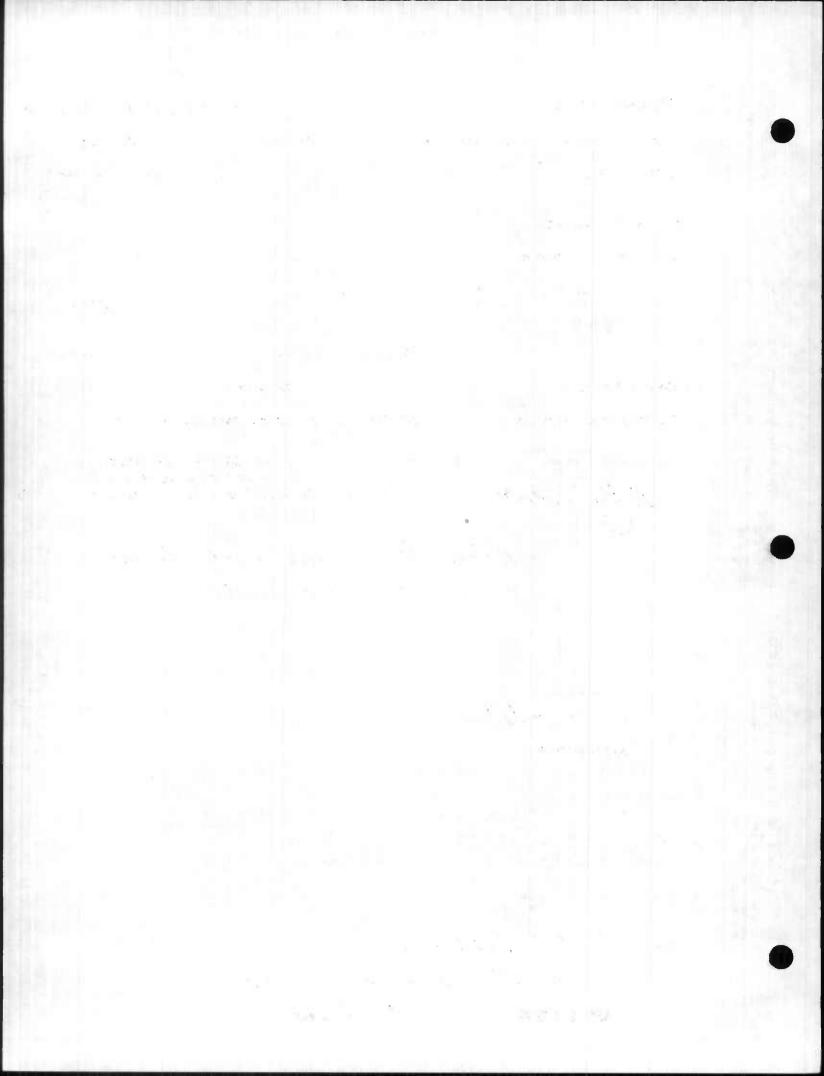
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** Albert F. Richter April 26, 1999 2:35 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Oakland Garrett 6. Sax 1 M 2 □ F If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Deta of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) **Funeral** Min Months Days Hours Yrs 219-14-6281 86 **Director** May 12, 1912 Maryland Usual Rasidance of Dacadant Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Martlal Hygiene. Intent of Health and Martlal Hygiene. With if them 27 is a marked other than "natural", or fitems 23a or 28a-f show mit. If them 27 is a marked other than "ne the product of the Martla Carlo martla and or natural and product of the martla carlo martla and or natural an 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Garrett Oakland 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 304 Pergin Farm Road 21550 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ੴ No if Yes, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raça - Amarican Indien, Bleck, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Timberman & Farmer Timber and Farming 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be George Richter Mary Foy 19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Pauline Richter/Wife 304 Pergin Farm Road, Oakland, MD 20b. Place of Disposition (Nama of camatary, cramatory or other piece) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 XBuriai 2 Crametion 3 Ramoval from Stata permit. Page Department o Important: If any Injury or 4 Donetion 5 Othar (Specify) St. John's Church Cem. Apr 30,1999 Accident, MD 22. Name and Address of Fecility Newman Funeral Homes, P.A. 21. Signeture of Funeral Service Licenses Oleman 179 Miller St., PO Box 275, Grantsville, MD 21536 23a. Part1. Enfar the disaasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, of heer/failura. List only ona causa on aach lina. Intarval Batween Onsat and Death Physician fmmediata Causa (Final disaasa or condition resulting in deeth) /Medical XYRS cardiovascular disease Examiner Examiner corebrovarcular physician and s the bunal-transit that the death certificate be executed Sequantially list conditions, if any, laeding to immadiata causa. Enter UndarlyIng Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequanca of): d for use as t signed by the a Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24a. Wes an autopsy parformed? 24b. Were eutopsy findings available prior to Completed veumania peen completion of cause of daath? s certificate hes b director, page 2 s 20 No 1 Yas 2 No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica director, Be 25. Was casa raferred to medical axaminar? 26. Pleca of Death (Chack only ona) Hospitel: 1 Yas 3 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Manatiant 2 □ ER/Outpetient 3 □ DOA funeral 28d. Dascribe how injury occurred 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Naturel 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 Could not be determined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 4 Homicida 9 filled 24 hours a 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) end menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to the causa(s) end mennar stated. 29a. Cartifian Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signature and title of certifier 29c. Licansa number 29d. Date signad (Month, Day, Year) 30035 30. Nama and addrass of person who completed causa of daath (item 23a) (Type, Print) 0 OAKLAND 33 Memorial 5215 31. Data filad (Month, Day, Year)

State Registrar

APR 28 1999 32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nam	a (First, Middla,	Last)			ertificate of		2. Data of Dea			3. Time of Death
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/Medical Examiner	de Fasilia Mares (um <i>ber</i>)			4b. City, Town, or Le	April ocation of Daath	26, 199 4c. County		10:00 P
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Funeral* Director	5. Social Security N 233-26-7	lumber 6	S. Sax 1 M 2 F	7. Age (In yrs. 78) If Undar 1 Yaar Months Days	if Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Sept. 2	Year) 1920	9. Birthpl County Wes	laca (State or Foreig try) Virginia
pue *	Usual Rasidance o	f Decedant 10b. County		10c. Cit	y, Town or I	ocation				10	0d. Insida City Limits
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ifier death with the Ma r items 23a or 28a-1s notes must be not the Funeral Director	Mary.Land 10e. Street and Nu 838 Old	mber		, West		10f. Zip Coda	21531	1	log. Citizan of V US		try?
		ied 2 Married	d 1 XYas	2 🗆 No		Was Decedent of If Yas, specify Cub	Hispanic Orlgin? (Spean, Maxican, Puerto	ecify Yas or No- Rican, atc.)	14. Rac Blac Specify	e - Amaric ek, Whita, a Wh:	
led within 72 hours a ygiane. yer than "naturel", c it, tra Medical Exar Completed by	(Spec		grada complated,) (1-4or 5+)	16e. Dec (Giv lifa.		pation during most of worked)	ing	16b. Kind of Bu		dustry
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alth ar	Sharol R				862	Old Morg	antown Rd		ndsville	, MD	21531
Department of Hes Department of Hes Important: If Item any Injury or othe	20a. Method of Dis 1 Buriel 2		Removal from	Stata	amatary, cr	position (Nama of amatory or other pla		Data	20c. Location -		
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permit. Pa Departmen Important: eny injury	21. Signature of Fi	meral Service Lic) our	naw			ess of Facility New r St., PO				P.A. le, MD 21
Physician /Medical Examiner	23a. Part1. EntaN shock, or has Immediate Ceuse diseasa or condition rasulting in daath)	(Finel		HEROSC	LERO'		OIOVASCU				Approximata Interval Betwaan Onsel and Death 5 years
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death certificate be executed e attending physician and of for use as the burial-transit is Iclan/Medical Examir	rasulting in daath)	5	d	Due to (o	r as a conse	equence of):					
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been s should				_				24a. Was a perfor		ava	ara autopsy findings allabla prior to mpletion of causa daath?
The law ate has be page 2 s								1 🗆 Y	as 2 No	10	Yas 2□ No
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		5 Pending Invastigat	tion	a of Injury nth, Day Year)	28b. Tima Injury	Wo	ny at ork?] Yas 2 ☐ No	28d. Describe h	ow Injury occur	red	
Ne Hospital or Attending P 12 A hours alter death Petuneral Director: After to pletaty filled in by the funeral edical Certification:	3 ☐ Suicida 4 ☐ Homicida	6 Could no detarmin	ed 288. Piec	e of Injury - Ai h ding, etc. (Specii	oma, farm, s	treal, factory, offica		28f. Location (S City or Tow	Street and Numb m, Stete)	oer or Rura	Il Routa Number,
in 24 hou he Funer pletaly fill edical	29a. Certifier (Check only one)		caminer: On tha I				lme, dete end pieca, opinion, deeth occur				
	29b. Signatura and	titla of certiller	7 Vous	mar	_14	D25	sa number 759		29d. Data signe April		
SHIVA	30. Name and add		no completed cau	usa of daath (Iter	n 23a) (Type		Acciden	+ MD 2	1520		

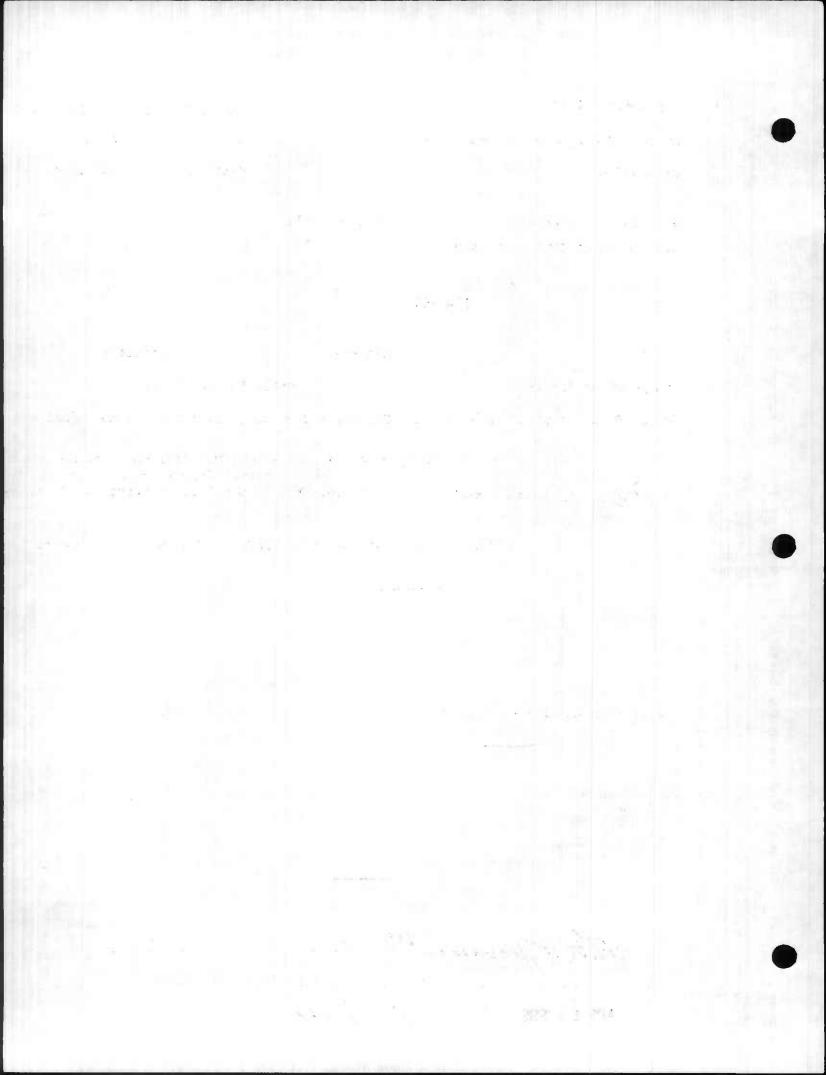
b. Sports

DHMH 16 Rev 6/95

State

Registrar

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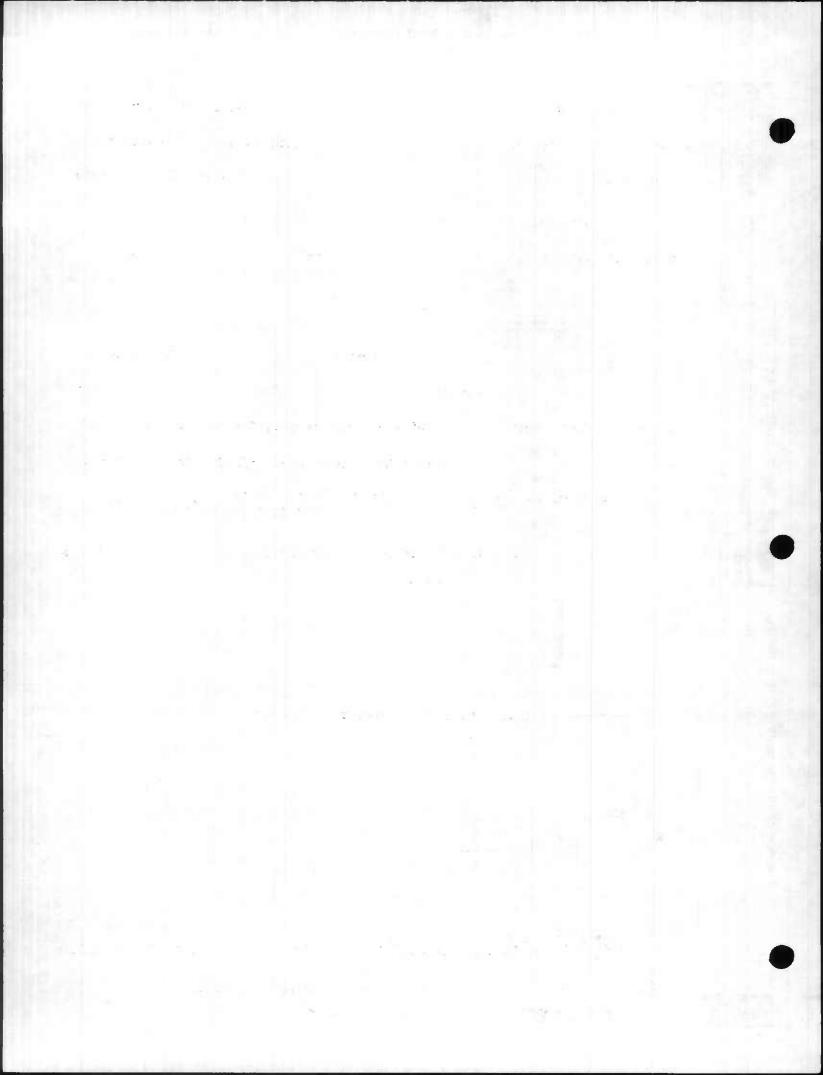
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1999 **Physician** April 28, 11:35 PM Garry David Ridder /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Grantsville Garrett Goodwill Mennonite Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10XM 2□ F Yrs. Director 213-01-5046 84 May 18, 1914 Maryland Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examenation notified at 1 Yee 2 No Director Accident MD Garrett 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21520 USA permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Expression and 26. 8715 Rock Lodge Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Tyes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 IXNo Specify: Specify þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coal Company Chemist 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Emma Pritts Ridder Elmer 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Lancaster/Niece 8992 S. Bayview Dr., Chestertown, Md. 21620 20a. Method of Disposition 20c. Location - City or Town, State 1 StBuriel 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Garrett Co. Mem. Gardens 5/2/99 Oakland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Einest A. Riley, g Stewart Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth Physician /Medicai Immediate Cause (Final disease or condition resulting in death) chronic lymphocytic leukemia years Examiner Due to (or es e consequence of) Examiner physician end the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 80 USB ed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Arteriosclerotic Cardiovascular Disease Division of Vital Records, by 8 24b. Wera autopsy findings available prior to been si 24a. Was an autopsy performed? Completed completion of ceuse of death? certificata has t 1 ☐ Yes 2 No 1 Tes 2 No Hospital or Attending Physician: 24 hours after deeth. Funersi Director: After this certificately filled in by the funeral director, 25. Was case referred to medical examiner? Be 28. Piece of Deeth (Check only one) Other: 457 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 200No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours after Funeral Dire letaly filled in b The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of 29c. License number 29d. Date signed (Month, Day, Year) D25759 April 29, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walter K. Naumann, M.D., PO Box 247, Accident MD 21520 31. Dete filed (Month, Day, Year) 32. Registrar's Signature APR 3 0 1999 Registrar

DHMH 16 Rev 6/95

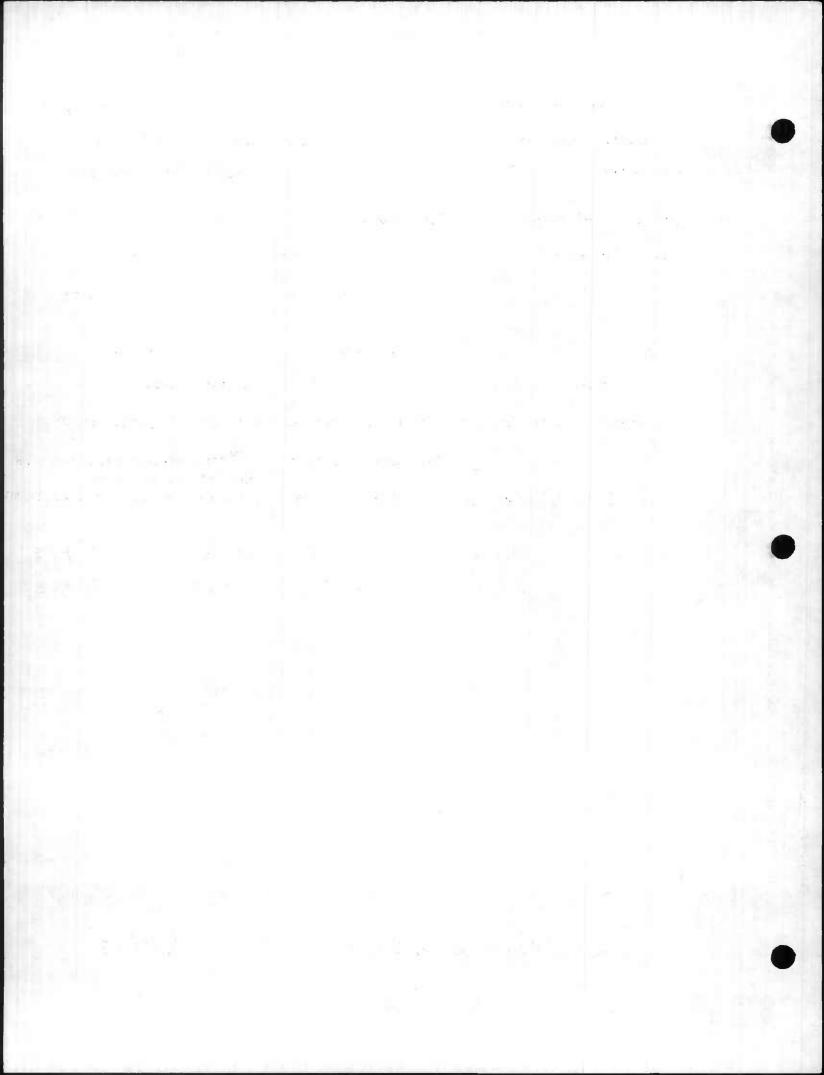


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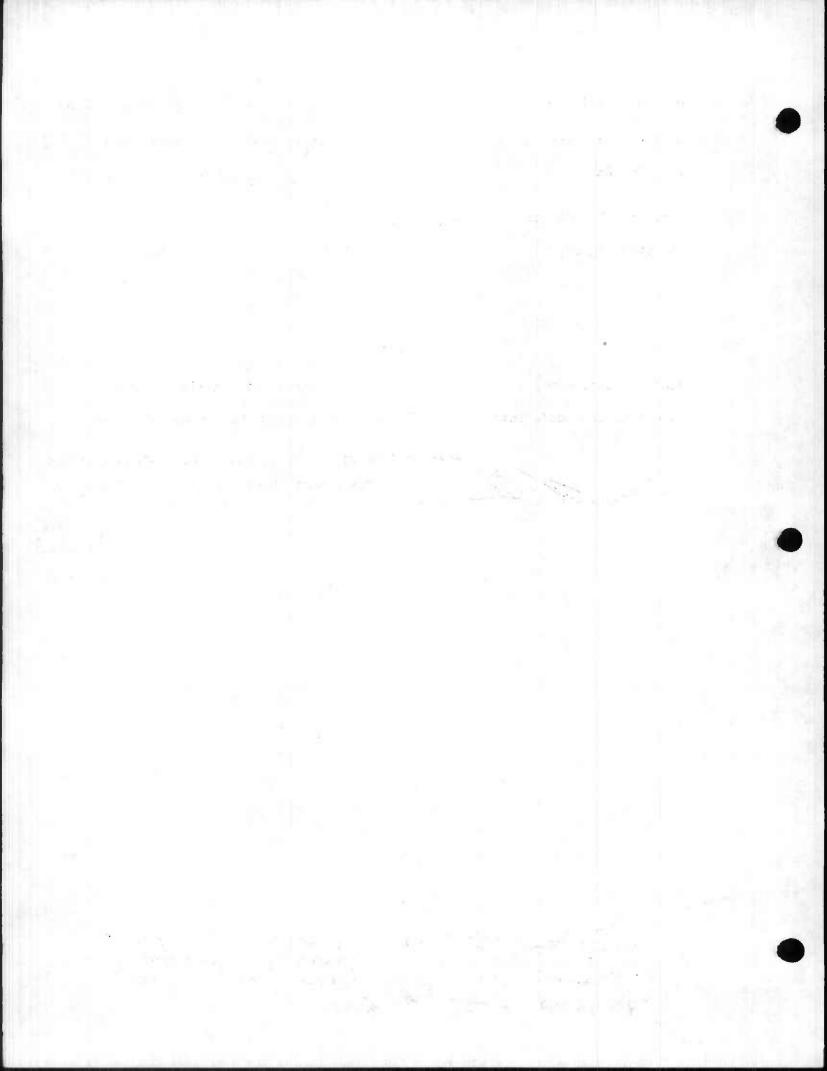
State of Maryland / Department of Health and Mental Hygiene

Gertificate of Death

	Certificate of Death Reg. No.										
Physician	Decedent's Name (First, Middle, Last) Iva Rene SMITH						2. Dete of Deeth Month Dey Yeer 1999 0128				
/Medical Examiner	4e Fecility Neme (If not institution, give street and number) Washington County Hospital					4b. City, Town	, or Location of Deal				
Funeral Director		5. Sex 1 □ M 2 ☑ F	Sex 7. Age (In yrs. lest birt		If Under 1 Yes	ar If Under 24	Hrs. 8. Dete of Bi		9. Birthplace (Stet Country) Maryland	e or Forei	
how	Usuel Residence of Decedent 10e. Stete 10b. County			City, Town or Location					10d. Inside City Lim		
or 28a-f show be notified at Director	Maryland Washin	Ha	Hagerstown					9\$ 2 I			
ygiene. Nethan "naturel", or iteme 23e or 28e-f eho nt, the Medical Examiner must be notified at Completed by Funeral Director	10e. Street end Number 1114 Salem Aven			10f. Zip Code	21740			Og. Citizen of Whet Country?			
	11. Maritel Status 12. Wes Decedent Evenue Armed Forces? 1 Never Merried 2 Merried 1 Yes 2 No			er in U,S. 13. Wes Decedent of Hispanic If Yes, specify Cuban, Mexi			? (Specify Yes or Noverto Ricen, etc.)	e - American Indien, ck, White, etc.			
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gir Year or D	/0		1 ☐ Yes 2 ☒ N	No Specify:		Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16e. Decedent's Usuel Occupation (Give kind of work done during most of wo			l working	16b. Kind of Business/Industry			
Con	0-5	0			homemaker				her own		
refinition to a paround on the state of the	17. Fether's Neme (First, Middle, Last) Charles P. Shry						Bertha				
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City of the C									0	
	Mr. Robert L. Smith/husban						lagerstown	_			
	20e. Method of Disposition 1 □ Suriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)			20b. Place of Disposition (Name of cametery, cremetery or other place) Rest Haven Cemetery			5 ^{Ma} 1999	May , 1999 Hagerstown, Maryla			
	21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 2								nd 2		
	Immediate Ceuse (Finel disease or condition resulting In deeth) - Acute Myocardial Infarction - Due to (or es e consequence of): - Atherosclerotic Cardio vascular disease - Due to (or es e consequenca of):										
e etta ed for	Pert II. Other eignificant condition	s contributing to d	ontributing to death but not resulting in the underlying ceuse given in				23b. Did tobacco use contribute to the cause of de			se of de	
ed by the detache							1	1 Yee 2 No 3 Probably 4 Unk			
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the etter completely filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for Medical Certification: To Be Completed by Physicial							24a. We per	s en eutopsy formed?	24b. Were eutop evaileble pri completion of deeth?	or to	
							1 🗆	Yes 2 No	1 ☐ Yes 2	2□ No	
	25. Wes case referred to medical exeminer?							Deeth (Check only one)			
	1 Yes 25 No 27. Menner of Deeth Volume 5 Pending 2 Accident investigs	28e. Dete (Mon	Inpatient 278 of Injury th, Dey Year)	ER/Outpetient 3 DOA Other: 4 Nursing 28b. Time of Injury Work? 1 Yes 2 No			28d. Describe	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
	3 Suicide 6 Could no determin	of be ned 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street end Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.										
	29b. Signature of the Company of the										
	30. Name and eddress of person w	ho completed ceus	se of deeth (Item	(23e) (Type,	Print)	Canson	is Rd	Hay	Md		
State	31. Dete filed (Month, Day, Year)	1999 32. F	Registrer's Signe		9. An	2 1		1			



		Decided News (First Middle Acc		C	ertificate o	f Death	1.5.45	Reg. No.	15789
sician		Decedent's Name (First, Middle, Las					2. Dete of De Month	Dey	3. Time of De
edical	Н	Dorothy Amelia Sp					May	2 199	
miner ral	5	e. Fecility Neme (If not institution, give Colton Villa Nurs Social Security Number 214-09-1086 Jsuel Residence of Decedent	ing Home	n yrs. lest birthda 93 Yrs.	y) If Under 1 Yea Months Day		DWN 8. Dete of Bir	Washin	
	1	Oe. State 10b. County	10	c. City, Town or	Location				10d. inside City I
jo		Maryland Washing	ton	Hagersto	own				1) Yes 2
1 2	1	0e. Street end Number			10f. Zip Code			10g. Citizen of Wh	et Country?
1 2	5	750 Dual Highway			21	740		USA	
Be Completed by Funeral Director	2	1. Meritel Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:	r in U,S. 13	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispenic Origin? (: iben, Mexican, Pue o <i>Specify:</i>	Specify Yes or No to Rican, etc.)		American Indien, White, etc.
Completed		15. Decedent's Ed. (Specify only highest grad Elementery/Secondary (0-12)	cation de com <i>pleted)</i> Coilege (1-4or 5+)	16e. Dec (Gh life Tel		upetion e during most of wo red)	orking	16b. Kind of Busi	
Be		7. Fether's Neme (First, Middle, Last)				18. Mother's Ne	me (First, Middle	, Maiden Sumeme)	
To		Jacob M. Springer				Bernade	etta Ami	lia Johns	on
	1	19e. Informent's Name/Relationship (T)						er, City or Town, Si	
	-	Robert M. Johnson, Oe. Method of Disposition			Chartri position (Neme of	dge Drive	Hager:	stown, MD	
	1	1 Burial 2 ☐ Cremetion 3 ☐ F	Removel from State	cemetery, cr	emetory or other p			20c. Location - Ci	
once	-	4 Donetion 5 □ Other (Specify)		Rose Hil	Cemete	ry May 5,	1999	Hagersto	wn,Maryland
SOUCE		31 Bart Enter the disease, or compishock, or heart fadure. List only o	.Col_				Wil	lamsport	ocheague S1
edical Examiner	o r	mmediete Ceuse (Final disease or condition esulting in death) Sequentially list conditions, eny, leeding to immediete euse. Enter Underlying Jeuse (Disease or Injury	b	stafic to (or es e cons		anone	4		Month
an/Medical	r	esulting in deeth) Lest	d.	to (or es e conse	equence of):				
1 000	P	ert II. Other eignificant conditions cor	ntributing to death but no	et resulting in the	underlying cause g	given in Pert I.	23b. Did	tobacco uae contr	ibute to the cause of d
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by Physician/M									
þ	-						24e. Wes	en eutopsy omed?	24b. Were autopsy find aveileble prior to completion of cause of deeth?
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Be Completed by	2	5. Wes case referred to medical examiner?	Hospitel:			Whor:	perfo	Yes 22No	aveileble prior to completion of cause of deeth?
To Be Completed by	2	examiner?	Hospitel: 1 □ Inpatient 28e. Dete of Injury (Month, Day Ye	2 ☐ ER/Outpeti	of 28c. Inj	ther: 4 Nursing	perfo	Yes 2 No	aveliable prior to completion of caus of deeth? 1 Yes 2 446
Certification: To Be Completed by	2	examiner? 1 Yes 2	28e. Piece of Injury (Month, Day Ye	28b. Time Injury At home, ferm, specify)	of 28c. Inj M 1[wher: 4 Nursing ury et ork? Yes 2 No	perference perfection in the p	Yes 22No one) dence 6 Other how injury occurred Street and Number wn, Stete)	aveileble prior to completion of cause of deeth? 1 Yes 2 And (Specify)
Certification: To Be Completed by	2	examiner? 1 Yes 2 100 7. Manner of Deeth 1 Energy Deeth 2 Accident 3 Sulcide 4 Homicide 9a. Certifier 1 Certifying Physical Certifying Physical Certifier	28e. Dete of Injury (Month, Day Ye) 28e. Plece of Injury building, etc. (S) elclan: To the best of my ner: On the besis of exe	28b. Time Injury At home, ferm, specify)	of 28c. Inj M 1[street, factory, office	wy et ork? Yes 2 No Notine, dete end place	perfection (Check only). Home 5 Resi 28d. Describe 28f. Location (City or To	Yes 2 No one) dence 6 Other how injury occurred Street and Number wn, State)	avelieble prior to completion of cause of deeth? 1 Yes 2 No (Specify) or Rurel Route Number or es steted.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Pau1 Shaw May 4 1999 8 AM Oscar /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Waldorf Healthcare Center Waldorf Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 5, 1921 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 100 M 2□ F 577-38-1209 77 Yrs. Vermont Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD Charles Waldorf 1 ☐ Yas 20 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be o 4140 Old Washington Rd. 20602 U.S.A. Funeral then "naturel", or flems the Medical Examiner m 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be flied within 72 hours after nant of Health and Mental Hyplece.

ant: If New 27 is marked other than "natural", or its ury or other traumatic event, the Medical Examics 1 Tryes 2 No If Yes, Give WW Year or Dates: WW 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ II 3 →Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Superintendent Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 Unknown Unknown 19a. tnforment's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret King/Friend 3 Mooncoin Circle Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 2003. Metropolitan Crem. 5/5/99 Alexandria, VA 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funaral Sarvice Licensee AREHART ECHOL'S FUNERAL HOME, PA. MO0945 P.O. Box 567 LaPlata, MD 20646 avo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting in deeth) End Stuge Examiner Examiner Atheroscleratio The lew requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last and Due to (or as a consequence of): Depression Box 68760, Physician/Medical Due to (or as a consequence of) USB BS P.O. Part it. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown of Vital Records, à 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed After this certificate has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of tnjury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 DNatural 5 Pending investigation To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

Robert avisos 31. Date filed (Month, Day, Year) 32. Registra s Signeture MAY 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

404

29d. Data signed (Month, Day, Year)

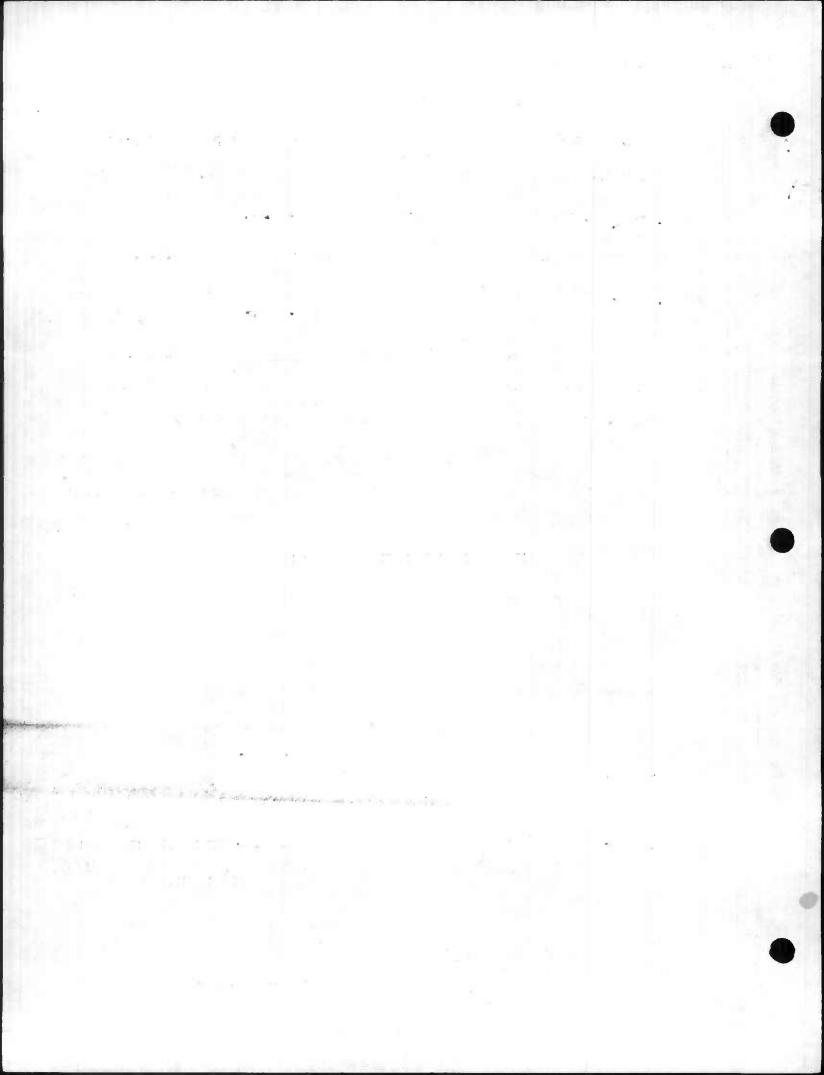
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/sician		Decedent's Name Caro	e (First, Middle,	F PER MEO		Smith				2. Date of De Month APRIL	Pag. No. Day 14,19	Year QQ	3. Tima of Death 3:05P.M.
ledical aminer	48	Facility Name (#	f not institution,	give street and n	umber)			4b. City,	Town, or L	ocation of Deat			J.UJF alti
	1 2	27316 BO	SSE DRI	VE				MECH	ANICS	VILLE	ST .MAI	RY'S	
eral ctor		Social Security No. 217-96-6 uat Residence of	742	Sex 1□M 2⊠F	7. Age (In yr. 29	s. last birthday; Yrs.	Months D		der 24 Hrs. rs Min.	8. Data of Bin (Month, De May 2,	y, Year)	9. Birthplac Country Maryl	ce (Stata or Foreign y) .and
frector	108	. State aryland	10b. County	ry's		City, Town or L Mechani	ocation LCSVILL	9		•	77	100	1. Inside City Limits
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ry or other	208			☐Removal from	n Stata	cemetery, cre	osition (Nama omatory or other	r place) P			20c. Location		
Boos Plus	21.	Signature of Ed			/	2	2. Nama and A	ddrass of Fa	cility	Lee F	uneral 1	Home,	arts
ian cal ner	tmi dis res	a. Part1. Enter the shock, or hear shock, or hear mediata Cause (lease or conditional find the shock)	Finat		JS OXIDE		TION AND						nterval Between Onset and Death
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DHMH 16 Rev 6/95

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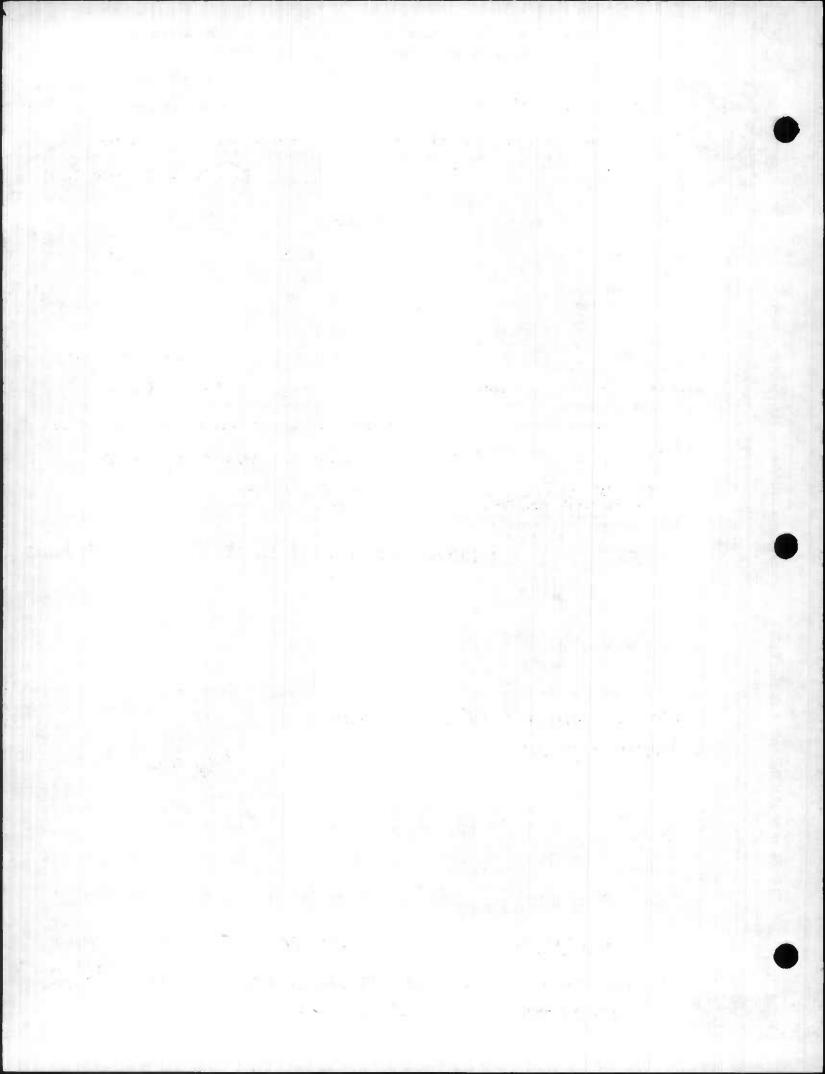
State of Maryland / Department of Health and Mental Hygiene

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5	1 XNaturei 2 ☐ Accident	5 Pending invastiga	(Mon	th, Dey Year) injury	V	lork? ☐ Yes 2 ☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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ate		R. RICHT	ER, M.D.	Registrer's Si	gnature	MORIAL I		OAKLAND,	MD 2153	50	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate	e of	Death			Reg. No.		
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Funeral Director	5. Social Security Number 217–28–9513 Usuel Residence of Decadent	6. Sex 1 M 2 □ F	7. Age (In yrs. lest	birthdey) Yrs.	If Under Months	1 Year Deys	If Under Hours	Min.	8. Dete of Bir (Month, De Dec. 20	th by, Yeer) 0, 1930		olece (Stete or Foreign ntry) nsylvania
Maryland f show	10e. State 10b. County	ltimore	10c. City, To	own or Lo	cation Balti	mor	0				1	0d. fnside City Limits
offer death with the Mar r ferms 23s or 28s-f el river must be notified Funeral Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cour	ntry?
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Pa Pa	20e. Method of Disposition 1 🖾 Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (S)		State ceme	etery, crer	ceme	ther ple		4	Dete 1/29/99	20c. Location Swanto		
permit. Pages 1 et Department of Hea Important: if item 3 any injury or other pncs.	21. Signeture of Funerel Service	icensee	0.	S	tewar	t F	unera	1 Ho	me Oakland	L MD 2	1550	
requires that the death certificate be associed with the death certificate be associed with the death certificate by the attending physician and hould be detached for use as the burial-transit eted by Physician/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	e b c	Due to (or es	s e consec	quence of): quence ot):	ral	effi	USIO	ns			72 hours
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To the Hospital or Attending Physibin 24 hours elter death within 24 hours elter death completely filled in by the funeral completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifyin (Check only one) Madical	Examiner: On the b	e best of my knowled besis of examination oner stated.	dge, deati and/or in	h occurred vestigetion	et the ti	me, dete er opinion, de	nd plece, eth occur	end due to the rred et the time,	ceuse(s) end m date end pieca,	end due t	steted. o the ceuse(s)
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STIVA	30. Name and address of person ELIZABETH PYI	who completed cau	se of deeth (Item 23	e) (Type, HOPK	Print)	BA	IVIEN	ME	FOICAL	CENTR	ERE	1999 SNIIMORE 2)222
State Registrar	31. Dete filed (Month, Dey, Year) APR 2		Registrer's Signeture		. 1	oou	6					



B.K.S ROBERT WEA ITEMS Physician	1. Decedent's Nei	me (First, Middla, L	PER MEO G	Maryland 771 5-17-	WR Cel	tificate of	f Death	2. Deta of	Reg. No. Death	9 15791; Year 3. Time of Death
/Medica	Robert		Ε.		Weat	herhol		MAY	7, 1999	8:28 PM
Examine	and the state of t	(If not institution, g		iber)			4b. City, Town	n, or Location of Di RLAND	eath 4c. County ALLE	
Funeral Director	5. Social Security 212-84 Usuel Rasidance	-9905	Sax 1 M 2 F	7. Aga (In yrs. la 3 9		If Under 1 Yea Months Days			Day Year)	Birthplaca (Stata or Foreign Country) MD
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or 28a-f	10e. Street and N		- 97			10f. Zip Code			10g. Citizen of V	What Country?
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215-UU2U Din 72 hours after death w an instruct, or lears 23a Medical Examiner must		rried 2 Married	Armed Fore	2 K o	l l	Vas Decedent of I Yas, specify Cu I ☐ Yes 2☐ No	ban, Mexican,	n? (Specify Yes or Puarto Rican, etc.)		ea - American Indian, ck, White, etc.
Part Isal	/0-	15. Decedant's I			16a. Deced	lent's Usuel Occi	upation	d wading	16b. Kind of Bo	usiness/Industry
ING 21213-U be filed within 72 ho kil Hygiene. 3 other than "natur vvent, the Medical.	Elamantery/Sec	condery (0-12)	College (1-	4or 5+)	tifa. L	kind of work don DO NOT use retir —emplo	red)	or working	Sign S	hop
and other and other cevent, I	17. Fathar's Name	(First, Middle, Las	,	1					ldle, Maiden Surnan	
Menta di de		m E. We	atherho	olt			Joan	L (Va	nMeter)	
Mary nd 2 sho uth and 1 27 is ma r traums		Name/Ralationship . Weath						or Rural Routa Nu t; Cumbe	mber, City or Town, erland	Stata, Zip Code) MD 21502
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Demit Depart Import any in	21. Signature of F	meo 7	Cay	sell	22	scarpe.	Par Tario		lome P.A	•
Physician /Medical	23a. Party. Enter shock, or ha	the disaasa, or content feilura. List onl	mplications that was y ona causa	used tha daath. ch lina.	Do not enta	ar tha moda of dy	ying, such as co	ardiac or raspirator	y arrest,	Approximata Intervel Between Onset and Death
Examiner	disaase or condit resulting in deeth	ion	a. ALCOHOL				ALATION A	ND THERMAL	INJURIES	1
				Due to (or	as a conseq	uanca of):				1
be executed ician and burial-transit	Sequentially list of if any, laading to causa. Enter Und	immedieta darlying	ı b	Dua to (or	as a conseq	uance of):				
certificate ding physise as the	Cause (Disease of that Initiated evan rasulting in death)	its	c	Due to (or e	es a conseq	uence of):			· ·	
death death ad for u	Part II. Other sign	ificant conditions	contributing to des	ath but not resuit	ting in the ur	ndarivino causa o	iven in Part I	23h. [old tobacco use on	ntribute to the cause of death?
E & D .									Yes 2 No	4.0
requi								24a. V	Vas an autopsy erformed?	24b. Were autopsy findings available prior to completion of cause of death?
The law ate has page 2								1	Yas 2 No	1 Yes 2□ No

Be Completed by Physician/Medical Medical Certification: To

1 Yas 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only one) Hospitel: 1 Inpatient 2XXER/Outpatient Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) XXYas 2 No 3□ DOA 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? P M 1 ☐ Yas 2 No HOUSEFIRE

1 Natural 5 Panding investigation MAY 07, 1999 7:35 2 Accident 6 Could not be detarmined 3 Suicida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicide

RESIDENCE

CUMBERLAND, MD. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. Licansa number

O.C.M.E

29d. Data signed (Month, Day, Year) MAY 9, 1999

28f. Location (Street and Number or Rural Route Number, City or Town, State) 716 1/2 FREDERICK STREET

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

THEUDORE 111 Penn Street, Baltimore, Maryland 21201

31. Data filed (Month, Day, Year) State MAY 1 3 1999 Registrar

29a. Certifiar (Check only one)

29b. Signatura and titla of certifia

2. Registrar's Signature

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be exe

certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

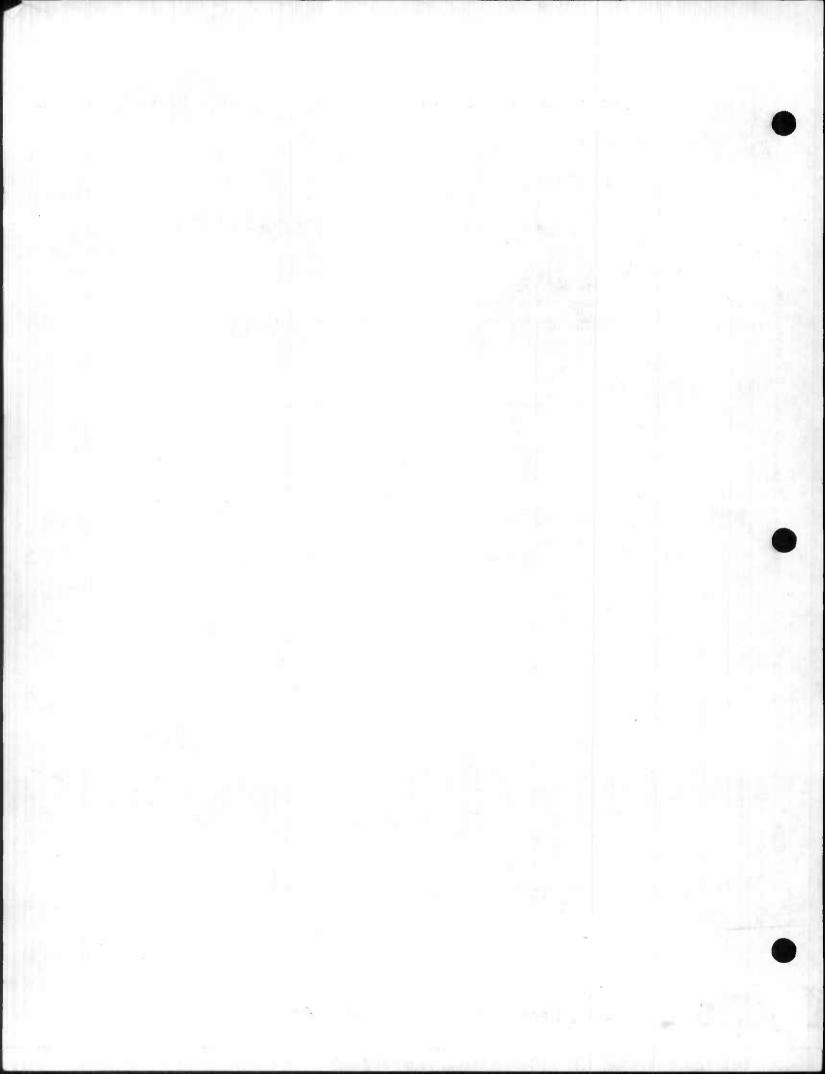
Division of Vital Records, P.O. Box 68760,

3) Lever is of water

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State of Maryland / Department of Health and Mental Hygiene

4a Facility Name (If not institution, g Sacred Heart H	LAVERNE Wive street and number) Iospital Sex 7. Age 8 Tett Highway 12. Wes Decedent E Armed Forces? 1 Yes, Give Yes, Give Yes, Give Yes, Give Year or Detes: Education rade completed) College (1-4or 54)	ver in U.S.	yrs. Minute of the state of the	Of. Zip Code 215	Cumber H Under 24 Hours 661	, or Location of Dea	25,199 th 4c. County Alle	9. Birthplece (State or Fore Country) West Virgini 10d. Inside City Lim 1 Yes 204
Sacred Heart F. 5. Social Security Number 6. 220-10-0352 Usuet Residence of Decedent 10a. State 10b. County Md Garr 10e. Street and Number 15398 Maryland F. 11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementery/Secondary (0-12) Unknown 17. Father's Neme (First, Middle, Las Amos Bean	Action Process of the College (1-4 or 5-4) Sex 7. Age 7. Age 8 Total 7. Age 8 Total 7. Age 8 Total 7. Age 8 Total 7. Age 8 Total 7. Age 8 Total 7. Age 8 Total 8 Total 9 Tota	35 10c. City, To SW Ever in U.S.	yrs. Minor Location Vanton	on Days On Zip Code 215	Cumber H Under 24 Hours 661	land Hrs. 8. Dete of Bi	Alle	9. Birthplece (State or Fore Country) West Virgini 10d. Inside City Lim 1 Yes 204
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19e. Intorment's Neme/Retationship					Ber	Lia Howa	yshell	
	(Type, Print)	15	9b. Mailing A	ddress (Stree	t and Number o	or Rural Route Numi	ber, City or Town	, Stete, Zip Code)
Kenneth Wildman/	Son		15584	4 Maryl	land Hwy	y., Swan	ton, MD	21561
20a. Method of Disposition		20b. Place	of Dispositio	n (Name of bry or other pla	(00)	Dete	20c. Location	- City or Town, State
1 Burial 2 Cremetion 3						14/20/00	Connta	\
	**	ML. Z	1			4/28/99	Swanto	n, MD
1 7 -/	111	0	22. Na	ILIE BIN VOOR	ass of Fechity	111	Church	Street
1. Way	he Don		Boa.	L Funer	al Home	e Wes	ternport	, MD 21562
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initied events resulting in death) Last	б.	Due to (or es			nŝerce			1 year
Pert II. Other aignificant conditions	contributing to death but	t not resulting	in the under	tying ceuse gi	ven in Part I.	23b. Dio	l tobacco use co	ontribute to the cause of de
Perstie Men	pis me					10	Yes 2110	3 Probably 4 Unkn
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Hymosenson						24a. We per	s en autopsy formed?	24b. Were eutopsy finding available prior to completion of cause of death?
								1 ☐ Yes 2 ☐ 1√10
examiner?	Hospital:			100	hor			
	1 La Inpatien		-	JU DOV	4 LI NUISI			
1 Statural 5 Pending	(Month, Day	Year) 28b	Injury				how injury occur	rred
3 Suicide 6 Could not 4 Homicide determine	d 20e. Piece or injul		farm, street,	fectory, office		28f. Location City or To	(Street end Numi	ber or Rural Route Number,
29a. Certifier (Check only one) Certifying P (Check only one)	iminer: On the basis of e	examination e	ge, death occ and/or investi	curred at the ti gation, in my	ime, date and p opinion, death	place, end due to the occurred et the time	cause(s) end m , date end plece,	anner es stated. , end due to the cause(s)
29b. Signeture and title of certifier	_			29c. Licen	se number		29d. Date signe	ed (Month, Dey, Year)
105/		m.n		no	2051-		APRII	L 271999
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925 Bishop wa			serta	rel m	0 905	70.7		
31. Dete filed (Month, Day, Year)		r's Signature						
	21. Signeture of Funerel Service Lice 22a. Part1. Enter the disease, or conshock, or heert tellure. List only Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the initieted events resulting in death) Last Pert II. Other algnificant conditions Pupper user the injury that initieted events resulting in death) Last 25. Wes case referred to medical examiner? 1	21. Signeture of Funerel Service Licensee 22. Part1. Enter the disease, or complications that caused shock, or heert teilure. List only one cause on each lin tmmediate Cause (Finel disease or condition resulting in death) 23. Part1. Enter the disease, or complications that caused shock, or heert teilure. List only one cause on each lin tmmediate Cause (Finel disease or condition resulting in death) 24. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet intileted events resulting in death) Last 25. Wes case referred to medical examiner? 26. Wes case referred to medical examiner? 27. Manner of Death 28. Date of Injun (Month), Day investigation 3 Suicide 6 Could not be determined 28. Place of Injun (Month), Day building, etc.	21. Signeture of Funerel Service Licensee	21. Signeture of Funerel Service Licensee 22. No. 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart teilure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequent cause. Enter Underlying Cause (Disease or injury their initiated events resulting in death) Last Due to (or as a consequent cause. Enter Underlying Cause (Disease or injury their initiated events resulting in death) Last Due to (or as a consequent cause. Enter Underlying Cause. 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Certifier (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time and menner steled. 25b. Signeture and title of certifier 29c. License number 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecifity Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teliure. List only one cause on each line. 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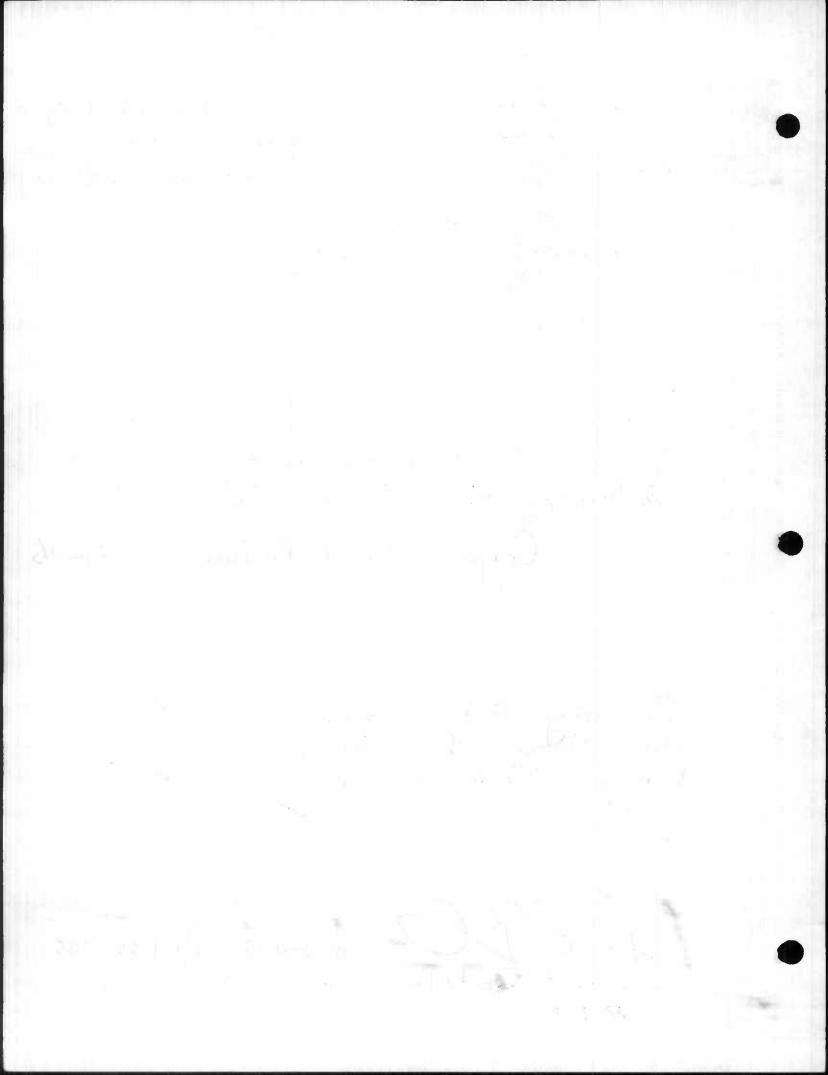


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Month Cleamon Washington Yommer 1:15 1999 ori 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Goodwill Mennonite Home Grantsville Garrett 5 Social Security Number If Undar 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 15€M 2□ F 175-18-9402 Director Yrs. 89 Feb 22, 1910 Pennsylvania Usual Residence of Decedent the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. toside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Exactions must be notified at Director MD 1 ☐ Yes 2 XNo Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10827 National Pike 21536 USA Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes ≥ 2 No if Yes, Give Year or Dates: 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced white "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifts. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 8 th Custodian Creamory & Auto Garage permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked otherny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surname Henry Yommer Annie Handwerk 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Edward Yommer/son 6999 Rock Lodge Rd., Accident, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata Grantsville Cem. 4 ☐ Donation 5 ☐ Other (Specify) April 23, 1999 Grantsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 21. Signature of Funantal Service Licensee 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or combilications that caused the death. Do not anter tha mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Physician /Medical Immediate Cause (Final disaase or condition resulting in death) ear 20 nuestive **Examiner** Due to (or as a consaquenca of): Examiner physician and s the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Physiclan/Medical Due to (or as a consequence of): use es ettending for use es ed by the e Part II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 25. Was case referred to medical examinar? certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 100 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Watural 5 Pending investigation death. 1 Yes 2 No d in by the f 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Yown, State) efter 4 Homicide within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as steted.
2 Medical Examinar: On the Dasis of exemination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. edicai 29a, Certifier (Check only one) the t 29b. Signature and title of certifier 29c. Licansa number Date signed (Month, Day, Year) 30. Neme and address of person who completed of death (Item 23e) (Type, Print) 36 amo 26 31. Data filed (Month, Day, Year) 32. Registrar's Signature State **APR 27**

DHMH 16 Ray 6/95

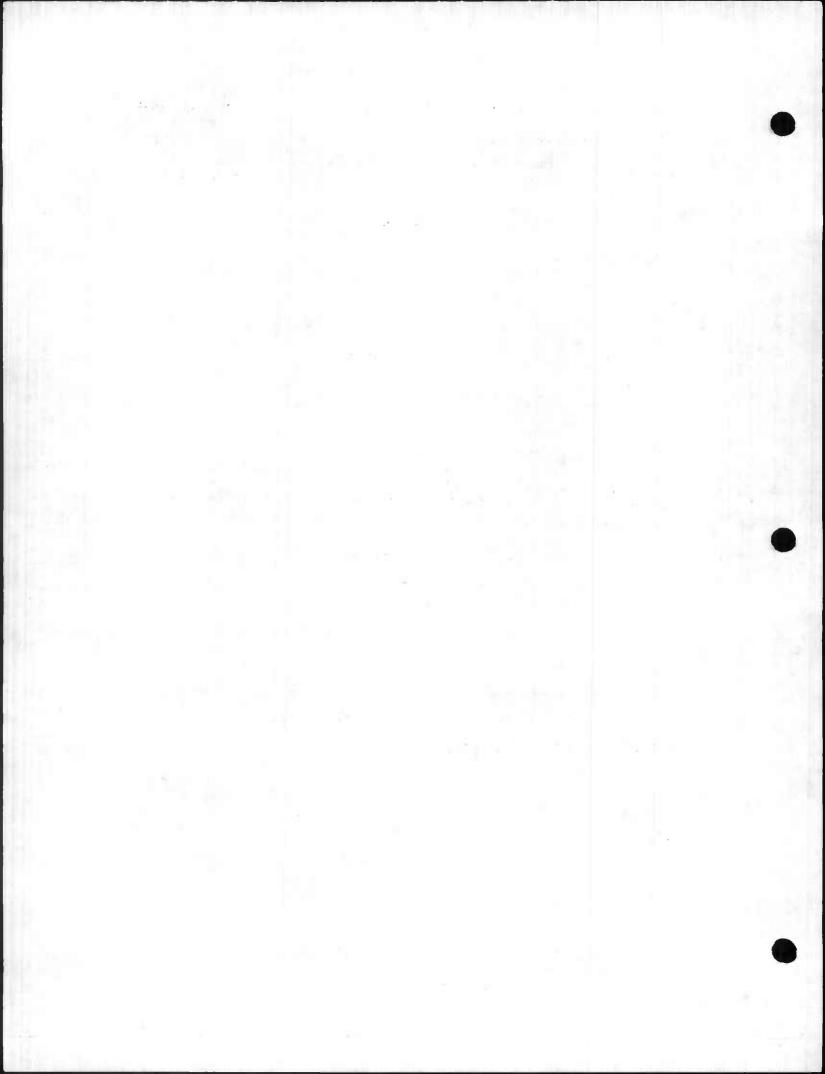
Registrar



State of Maryland / Department of Health and Mental Hygiene

sician	1. Decedent's Na	me (First, Middla,	Last)		00/1	ificate of	Douth	2. Date of De	Reg. No.	3. Tir	na of Death
			m ZAHN, Jr					Month MAV	03, 1999	Year	:01 AM
edical miner			giva street and numb				4b. City, Town, or	Location of Deat			OI AM
mmer	RAVENWO	OD LUTHE	RAN VILLA	GE			HAGERST	OWN		INGTON	
ral	5. Social Security	Number 6		Aga (In yrs. la	st birthday)	If Under 1 Yaar Months Days	If Under 24 Hr Hours Mir		rth	9. Birthplace (Si Country)	ate or Foreig
or	214-09 Usual Rasidance		1 ₹M 2□ F		Yrs.	Months Days	riouis mil		3 1905	Maryla	
	10a. Stata	10b. County		10c. City,	Town or Loca	ation					de City Limits
cto	Maryland	Washi	ngton	Hag	erstow	n		100		10	Yes 2 No
Directo	10a. Street and N	umber				10f. Zip Code			10g. Citizen of V	What Country?	
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Funeral	11. Marital Status	rried 2 🕅 Married	12. Was Decede	15?	13. W	as Decedent of H Yas, specify Cubi	lispanic Origin? (an, Mexican, Pua	Specify Yes or Norto Rican, atc.)	- 14. Rec Blac	e - American Indie ck, Whita, atc.	en,
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0			Zahn, Sr.				Clara				
		Name/Relationship								State, Zip Code)	5
	Linda Z 20a. Method of Di		Daughter	20b. Pla		Brawner		Data		nia 2016 City or Town, Sta	
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any page	150	outo,	Them	ull			- 1			Md. 217	40
	23a. Pert1. Enter shock, or ha	tha disaasa, or co art failura. List or	omplications thet cau	sed tha death. h line.	Do not entar	the mode of dyir	ng, such as cardi	ac or raspiratory a	rrast,	Approx	I Between
		erio a								Onset	and Death
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edicai	that initieted even rasulting in death	ts	C	Dua to (or a	as a conseque	ence of):				1	
			d								
Physiciany	Pert II. Other sign	ificant conditions	s contributing to deat	h but not rasult	ting in the und	lerlying causa giv	ren in Part i.	23b. Did	tobacco use co	ntribute to the ca	use of death
Y.	ARTERT	OSCLEROT	IC HEART	TSEASE	מדא/גו	TAI ETRI	מדדו אידר	N 10	Yes 2 No	3 Probably	4 Unknow
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To Be	axaminar? 1 Yas 25 27. Manner of Dec		28a. Data of I		injury		Yes 2 □ No				
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10 De	axaminar? 1 ☐ Yas 25 27. Manner of Dec 1 ☑ Natural	5 Pending invastigat	tion 28a. Place of		ne, iarm, stree	et, factory, office		28f. Location City or To	(Street and Numb wn, Stete)	per or Rural Routa	reuniber,
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Charles William ZAHN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 1999 MARGARET ABBOTT 8:30PM 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Deeth HERITAGE NURSING HOME DUNDALK BALTIMORE GENESIS 8. Date of Birth Month Pay, Year 04 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) VA. Min. 1□ M 21 F Months Days Hours 213 09 3874 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Rossvil 1 Yes 2 No + more MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 4 GLANHAD **JISA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status 12. Was Decadent Ever In U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BLACK 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOUSEWIFE 6 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Susie UNK ASHTON GOODE VENABLE 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NELDER GOODE 4 GLANHAD CT. BALTO., MD. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20s. Method of Disposition Date 20c. Location - City or Town, State 1 Aurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) CALVARY 5/15/99 BALTO., MD. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility JAMES A. MORTON & SONS F.H., INC The disease, or complications that caused the deeth. Do not enter the mode or dying, Such as cardiac or respiratory errest, • 21217 thick, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2/2 No 1 Yes 20 No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 1. Naturel
2 Accident 5 Pending 1 Yes Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide

Division of Vital Records, P.O. Box 68760 or Attanding Physicien: after death. Director: After this carific

Physician

/Medical

Examiner

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Funeral

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Completed

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7 is marked other than "natural", or flems 23s or 28s4 show traumatic avent, the Medical Examiner must be notified at

permit. Pegas 1 and 2 should be filed within 72 hours effer to Depertment of Haaith and Mental Hygiane. Important: If Nem 27 is marked other than "natural", or free any injury or other traumatic avent.

Physician

/Medical **Examiner**

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Hospital 24 hours 8 24 hours a

To the To the To the

funeral director,

Examiner

Physician/Medical

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Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

Baltimore, Maryland 21215-0020

with the Merylend

death

State Registrar 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number

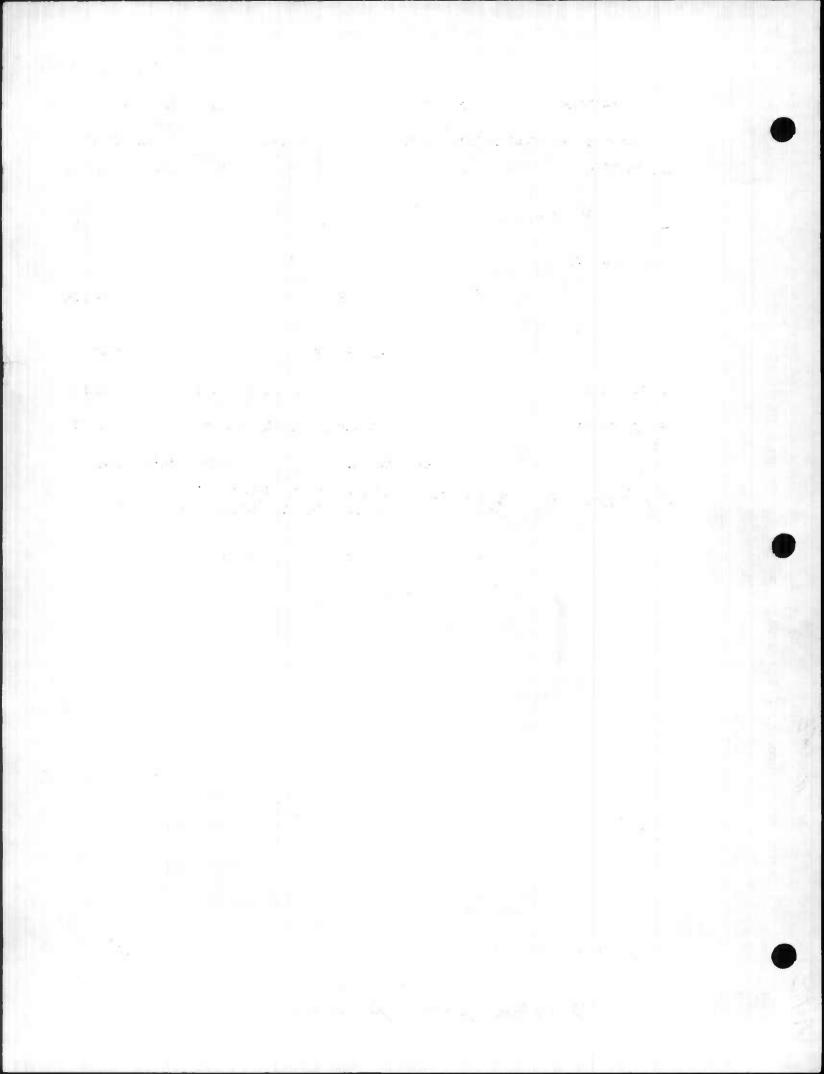
29d. Date signed (Month, Day, Year)

note ti rule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ne un. Ke

Baltine

32, Registrar's Signature 31. Dete filed (Month, Day, Year) MAY 16



Please Type or Print In Black indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Asah Seth May 3:32 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Prince George's Regional Hospital Laurel -aure If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 57 196-42-6409 09-06-41 **Director** Accra Ghana Usual Residence of Dacedent with the Maryland r 28m-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo MD Prince's George Laurel 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? Examiner rount be 9158 Canterbury Riding should be filed within 72 hours after death and Mentel Hygiene. Funerai 20723 USA 14. Rece - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify à 3 ☐ Widowed 4 ☐ Divorced Black Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) College (1-4or 5+) NA Unemployed 12th Grade 4yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be n end Mentel h Percy Asah Lucy Oye Asah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20723 permit. Pages 1 end 2 sh Department of Health end Important. If item 27 is m any injury or other traum Fred K. Asifo 9158 Canterbury Riding Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 X Buriat 2 Cremation 3 Removal from State ■ Donation 5 Other (Specify) Awudome Cemetery 06-08-99 Accra Ghana 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue milens that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, cause on each line. Approximate Interval Between Onset and Death List only **Physician** /Medical Immediate Cause (Final diseese or condition rasulting in daath) (010) Examiner Physician/Medical Examiner val 45101 that the death certificate be executed physician and s the bunal-trans Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) SES attanding p 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by ti 1 Yes 2 1 No 3 Probably 4 Unknown þ The law requires 24b. Ware autopsy findings aveilable prior to complation of ceuse of daath? 24a. Was an autopsy Completed peed page 2 s 2 DM 1 ☐ Yes 2 ☐ No 1 TYes certificata or Attending Physician: director Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 100 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28h Time of 28c. Injury at Work? After 5 Panding n 24 hours after deeth.

Ne Funerel Director: Alphately filled in by the fu 1 Yes 2 No Investigation after deeth. 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Hospital 29a. Cartifier 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and place, and due to the cause(s) and mannar as stated To the Hosp within 24 hor To the Fune completaly fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50678

State

Registrar

31. Date filed (Month, Day, Year)

Kajeer Batra

32. Registrar's Signature

MAY 17 1999

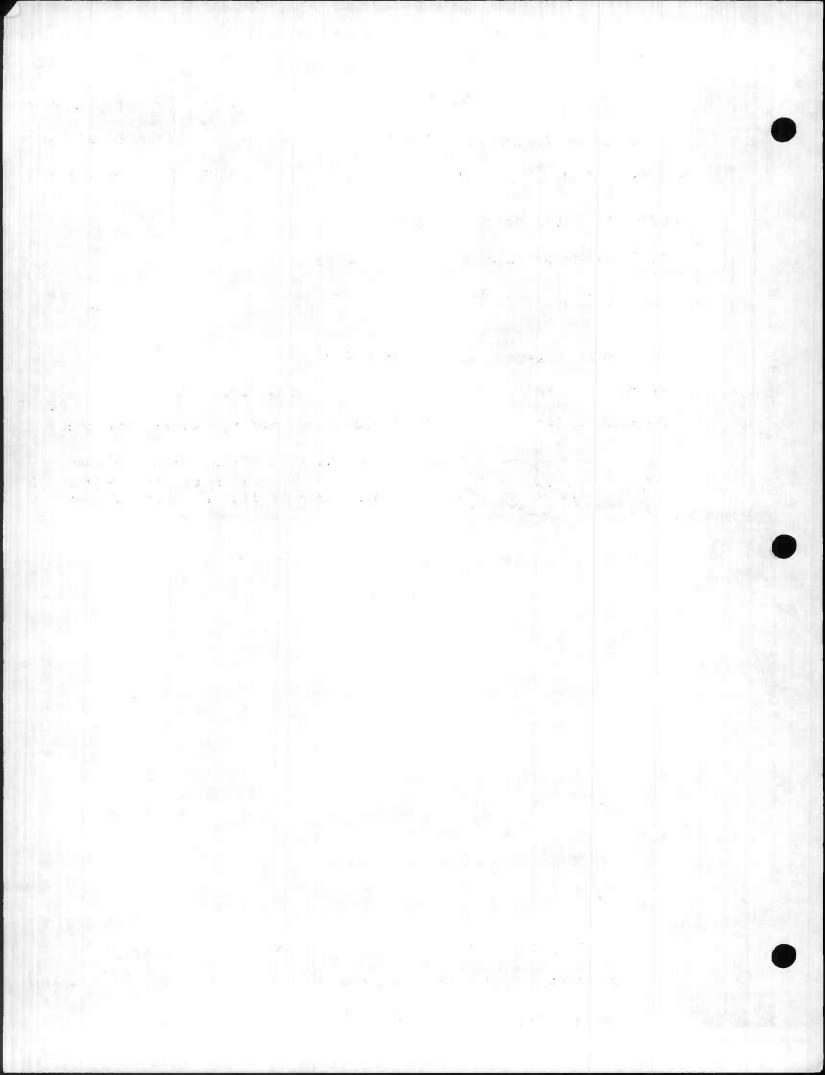
30. Name and address of person who complated ceusa of death (Itam 23a) (Type, Print)

M. wa

B. Sports

Silver Spring, MD

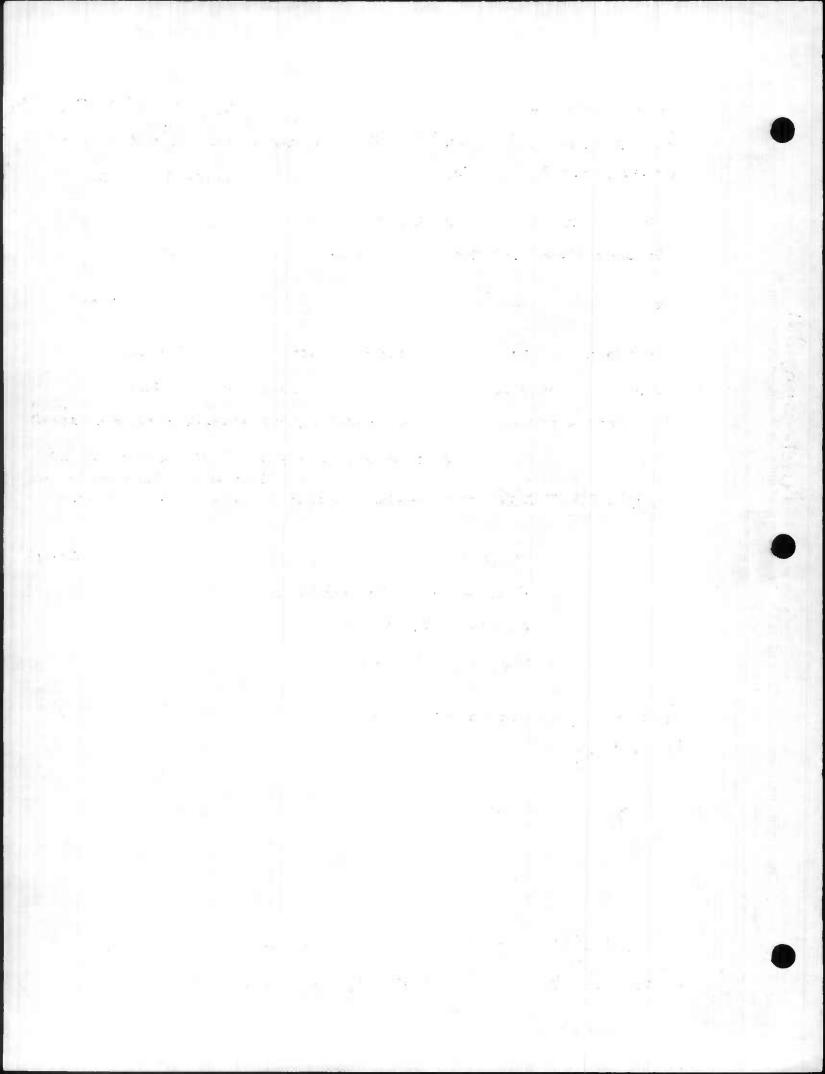
10801 Lockwood Drive, #325



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5800 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** 999 10:30AN J.D. Anderson 191 /Medical 4b. City, Town, or Location of Death County of Death 4a Facility Nama (If not Institution, giva street and number) Examiner Baltimore Franklin Square LOSE dale enter Hospital 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days M 20 F Months Hours 73 250-34-5805 **Director** 01-14-26 SC Usual Rasidence of Dacedant with the Maryland 10b. County 10c. City, Town or Location r 28a-f show 10a Stata 10d. Inside City Limits Yas 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Modesal Examinet must be a page. 21221 USA 405 Back River Neck Road Funerai 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Race - Amaricen Indian. Black, Whita, atc. 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2K No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 5th Grade Steel worker Company derson 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) Woodruff Mae Anderson Anne John 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20781 19a. Informant's Name/Relationship (Type, Print) 3839 Hamilton Street Hyattsville, Maryland Johnathan Anderson 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 05-15-99 Baltimore, MD 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Part. Enter the disease, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** Immediate Causa (Final disaasa or condition rasulting In death) /Medical Sepsis Examiner Examiner tabolic 1005.5 physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Last Dua to (or as a consequanca of): rai Division of Vital Records, P.O. Box 68760. lur by Physician/Medical Dua to (or as a consequance of): for use as 88 signed by the a d be detached f Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No Gastrointestina 24b. Wara autopsy findings available prior to Completed 24e. Was an autopsy performed? completion of cause of deeth? is certificate has I director, page 2 2 No 1 ☐ Yas 2 ☐ No 1 Tas or Attending Physician: Be 25. Wes cese refarred to medicel axeminar? 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this After this 28c. Injury at Work? 27. Mannar of Death 28e. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 1 Deleturel 2 Accident 5 Pending death. 1 ☐ Yas 2 ☐ No invastigation after death Director: A 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Certifier edicai (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of cedit 10053617 5/11/99 irson who completed ceuse of death (Itam 23a) (Type, Print) ranklin Square Drive Baltimore, MD 21237 9000 F Hassan er 31. Dete filad (Month, Dey, Yeer) 32. Registrar's Signatura State Registrar MAY 17 1999

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death Year Viola May 14, 1999 Baublitz 8:00 AM Amelia 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 11713 Terrytown Road Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 10-01-1912 5. Sociel Security Number 7. Aga (In yrs. last birthday) Birthplace (Steta or Foreign Country) 1 M 2 F Days Yrs. 216-30-6795 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland | Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11713 Terrytown Road 21136 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 14. Race - American Indien, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 Married Specify: White 1 Yas 2 No Specify: 3 AWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Social Security Elemantary/Secondary (0-12) 12 Years Collega (1-4or 5+) Examining Clerk Administration 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumema) Unknown Unknown 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Clarence Baublitz, Jr. 11713 Terrytown Road Reisterstown, MD 21136 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 5-17-99 Pikesville, Maryland Druid Ridge Cemetery 21. Signature of Funaral Service Licenses 22. Name and Addrass of Fecility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Md 21133-4784 Intar the disease of complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximata tnterval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) signosi Sequentially list conditions, if any, leeding to immadiata causa. Enter Undarlying Cause (Disease or Injury that initieted evants rasulting in death) Last Dua to (or as a consequence of) perlension Due to (or as a consequance of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Nerns 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours after death be appartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23 any injury or other treumstic event, the Medical Examination and

altimore, Maryland 21215-0020

Director

Funeral

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Completed

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the Maryland **ehow**

The law requires that the death certificate be executed physician and is the buriel-trans signed by the atte or Attending Physicien: funeral death. within 24 hours efter deat To the Funerel Director:

Division of Vital Records, P.O. Box 68760.

Hospital

Examiner Physician/Medical þ Completed Be Medical Certification: To filled in by

Part II. Other significant conditions of	contributing to death but not received			23b. Did tobacco use co 1 ☐ Yes 22 No	ntributa to the cause of death? 3 Probably 4 Unknown
	2.	01		24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
				1□ Yas 2 No	1 ☐ Yas 2 ☐ No
25. Was case rafarred to medical			28. Place of De	eth (Check only ona)	
axaminer? 1 ☐ Yas 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient 3 D	OA Other: 4 Nursing I	Home 5 Residence 6 □Oth	nar (Specify)
27. Mannar of Deeth 1 Natural 5 Pending 2 Accidant Invastigatio		28b. Time of tnjury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicida 6 Could not b datarmined	28a. Place of Injury - At h building, etc. (Speci	oma, farm, street, factor	y, office	28f. Location (Street and Numb City or Town, State)	ber or Rurel Routa Number,
29e. Cartifiar 1 Certifying Ph (Check only one) 1 Medical Exar	ysician: To the best of my knoniner: On the best of examinorand menner stated.	owledge, deeth occurred ation end/or invastigation	et the time, data and place , in my opinion, death occu	a, and due to the cause(s) and mu urred at tha tima, data and place,	ennar as stated. end due to the ceuse(s)
001 01-11 1-1111 1		100			100 0 0 10 1

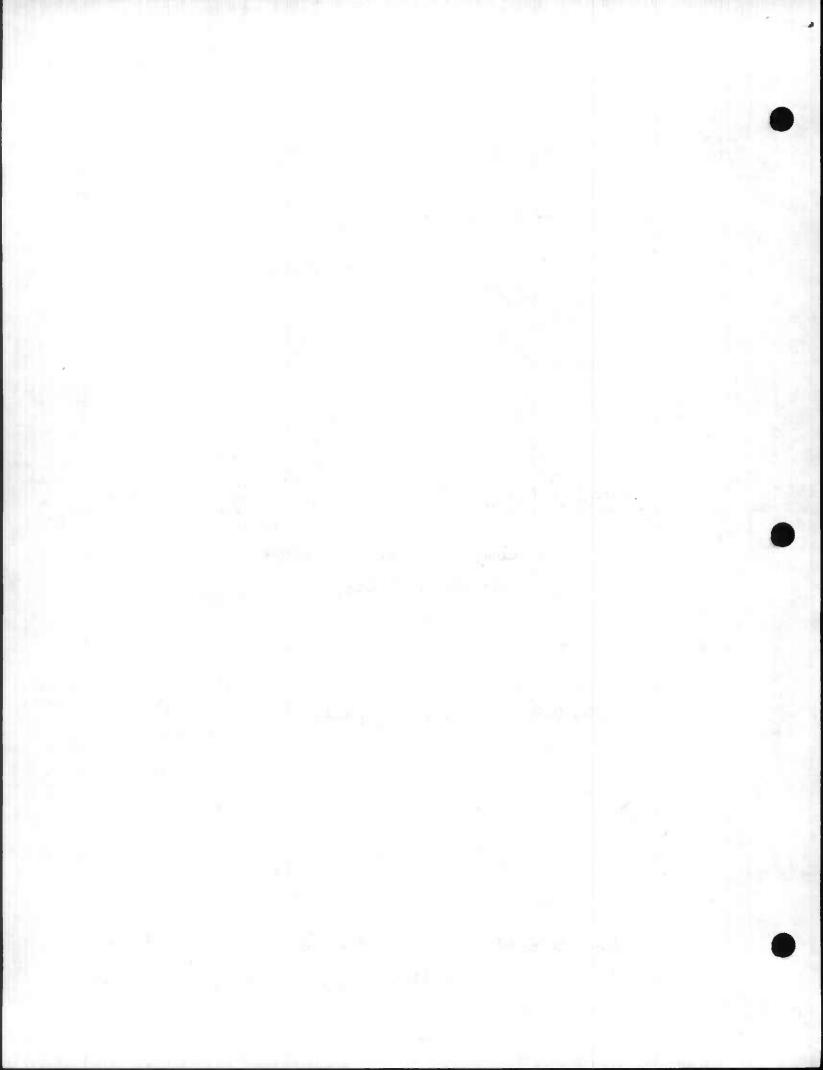
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31. Data filad (Month, Day, Year) **MAY 17**

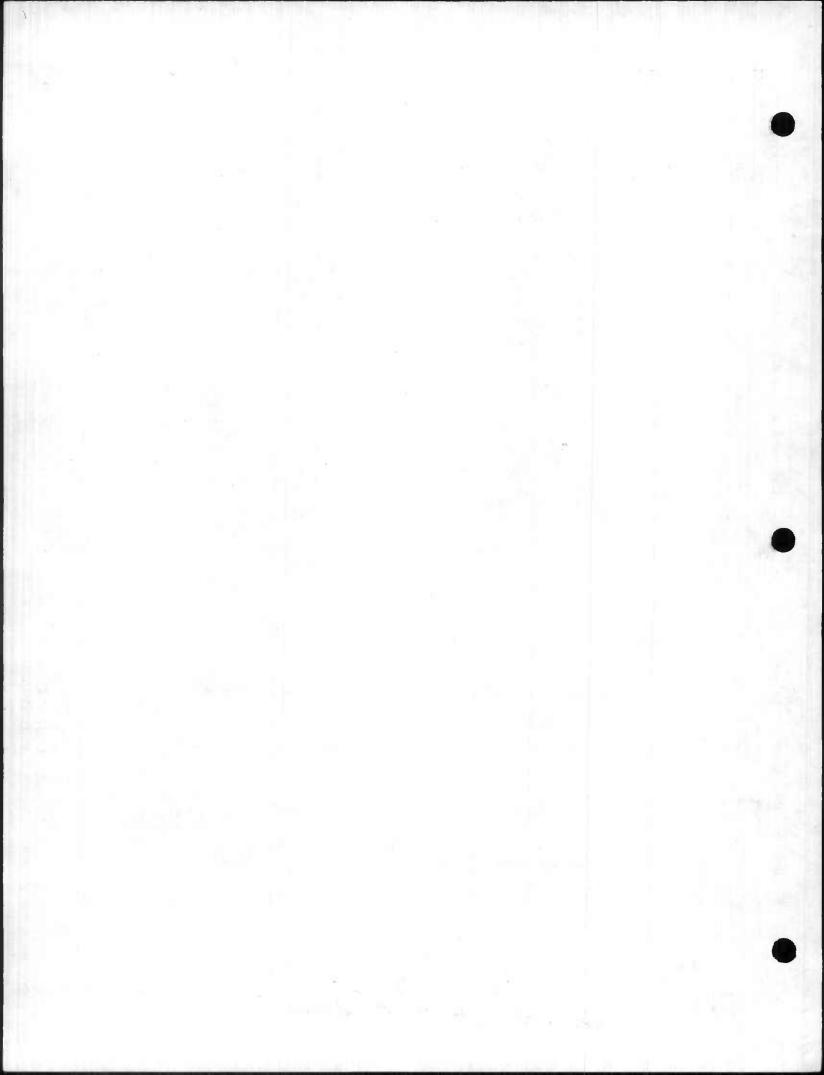


30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)



2. 23 PART I, PER MD G771	5-27,1999 WF	₹.	Certifica	ate of L	Death				, No. 99		5802
Decedent's Name (First, Middle, La an cal	George	H. Bon	hoff				2. Date of Month	10	Day	Year 999	3. Time of Death 1:35 P.M.
er 4a Facility Nama (If not institution, giv				4	b. City, Tow			Death	4c. County		2 .
Mariner Health of 5. Social Security Number 6. S		rnie e (In yrs. last bir	thday) If Und	ler 1 Year	Glen If Under 2		nie 8. Date d	of Birth	Anne		
	X M 2□ F		Yrs. Month	s Days	Hours	Min.	(Monti	h. Dav. Y	1926		olaca (State or Foreign otry) Vland
Usual Residence of Decedent							-				
10a. State 10b. County		10c. City, Tow								1	0d. Inside City Limits 1 ☐ Yes 2€ No
Maryland Anne Ar	unaer	Pasad		Zip Code				100	2. Citizen of W	Part Cour	
350 Lake Shore I	rive		101. 2	2112	2			100	U.S.		my r
11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Dec	edent of Hi	spenic Orig	in? (Spi	cify Yes	or No-	14. Race	- Americ	can Indian,
1 ☐ Never Married 21 Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 1 Yes 2 1 If Yes, Give Year or Dates:	No V.W. II		2⊠ No	n, Mexican, Specify:	Puerto	Hican, etc	.)	Specify:	k, White,	etc. nite
3 Widowed 4 Divorced 15. Decedent's Et (Specify only highest grave) Elementary/Secondery (0-12) 10th	ducation		Decedent's Us	sual Occupi	ation	of works	ina	16	Sb. Kind of Bu	siness/In	dustry
Elementary/Secondery (0-12)	College (1-4or 5	i+)	life. DO NOT	use retired)	OI WOIKI	'ny		Waiss	. 33	
10th 17. Father's Name (First, Middle, Last)	1		Reme1t		18 Mother	re Name	/Firet M	iddle Ma	Kaisor		untrions
	ohn G. Boi	nhoff			TO. MOUTHER				Biltz	9/	
19e. Informent's Name/Relationship (. Mailing Addre	ss (Street	and Number					State, Zip	Code)
Geraldine Bonhof	f / Wife	35	50 Lake	Shor	e Dri	ve	Pas	sade	na, Mai	ryla	nd 21122
20e. Method of Disposition 1 X Burial 2 Cremetion 3 C	Demoual from State	cemete	f Disposition (A ry, crematory o	r other plac			Date		c. Location -	City or To	own, Stete
4 Donetion 5 Other (Specific	y)	Meado	wridge	Memor	ial Pa	ark5	/14/9	99 I	Baltimo	ore,	Maryland
21. Signature of Funerel Service Deer	500				is of Facility				neral H		
23a. Part1. Entar the disease, or com shock, or heart failure. List only	plications that caused	the deeth. Do				_					Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	. Me	fas fai	he	13/	add	ev	1	400			Onset and Death
Sequentially list conditions, if any, leeding to immediate	Cons	Due to (or as a	consequence o	():	I	741	Ure	,			Lugar
Sequentially list conditions,	b	Due to (or as a	consequence o	t):		- (/					17(4
	C										
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions of		Due to (or es a o	consequence of	() :						i	
	d									- !	
Part II. Other significant conditions of	ontributing to death b	ut not resulting in	n the underfying	cause give	en in Part I.		23b.	Did tob		tribute t	o the cause of death
								1 Yes	2 N6	3 Pro	bably 4 Unknow
							24a.	Was an	autopsy	24b. W	ere autopsy tindings
								performe	ed?	CC	railable prior to empletion of cause death?
								1 Tes	212 No	1[Yes 20 No
25. Was case reterred to medical examiner?					26. Place	of Deat	h (Check	only one)		
1 Yes 2 10	Hospital: 1 Inpatie		stpatient 30		4 MINUI	rsing Ho		-	ce 6 Othe		(y)
27. Manne of Death 1 Naturel 5 Pending 2 Accident 3 Suicide 6 Could not b 4 Homicide	28a. Date of Inju (Month, Da	ry Year) 28b.	Time of Injury	28c. Injun World			28d. Desc	cribe how	injury occurr	ed	
2 Accident investigation 3 Suicide 6 Could not b		un. At home fe	M street fact		Yes 2□1		28t Locat	tion (Stre	et and Numb	er or Run	al Route Number.
4 Homicide detarmined	building, et	c. (Specify)	imi, street, lact	ory, omce				or Town,		57 07 1107	ar riodio riambor,
29a. Certifier 12 Certifying Ph	ysician: To the best onliner: On the basis of	examinetion en	, deeth occurre	ed at the tim	ne, date and pinion, deet	d placa, h occurr	and due to	the cau	ise(s) end me e and place, s	nner es s and due t	stated. o the cause(s)
29b. Signature and title of certified	and manner sta	1	2	9c. Licenso	e nu <i>m</i> ber			290	d. Date signed	(Mogth	Day, Year)
\$ 60 Costs	KIN	to a	0	02	009	4			05/1	19	P
30. Name and address of person who	completed cause of	eath (hem 23a)	(Type, Print)	001	1	1	21	1	1/1	110	- / /
Flight (I	orbatum	0 7	145	12619	won	1	d	Ofe	2 11	1/14	Md. 2106,
31. Date tiled (Month, Day, Year)		1				-					Not all the

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2 Medical Examinar: On the besis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

edical O

32. Registraris Signature

30. Name and address of person wife complated causa of death (lam 23a) (Type, Print) OSORNO,

29c. Licansa number

M.D.--9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

29d. Data signed (Month, Day, Year)

Mac

State Registrar

29b. Signifium and title of codiffs

DR. RICARDO J. 31. Data filad (Month, Day, Year)

with the Marylend

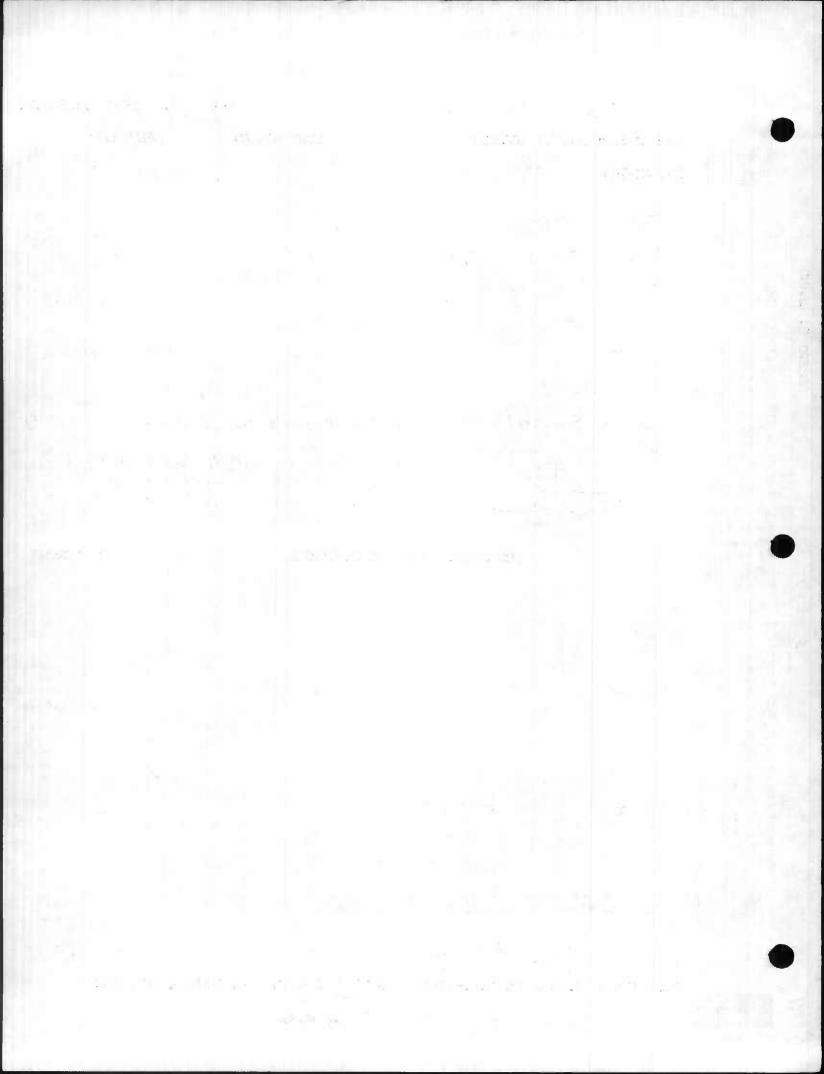
Maryland 21215-0020

the death certificate be executed

The law requires thet

Division of Vital Records, P.O. Box 68760,

BLAN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." ITFM#19a PFR F.H. G771 5-25-99 J 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 030 Month tslean **Physician** am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bultwore HUSPITA (If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 2⊠F 214-38-6782 Yrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 12 Yes 2 No Director NA Ma 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 6850 GC KOAV

12. Was Decedent Ever in U.S. Armed Forces? Westridge Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and of Healin and Mental Hygiene.

ant: If Nem 27 is marked other than "natural", or the ury or other traumatic event, the second 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 1□ Yes 2 No Black It Yes, Give Year or Dates: Specify: Specify: à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Lniversity Etementary/Secondary (0-12) College (1-4or 5+) thograde anitor MA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hslean Henry WISUn
19a Intormant's Wame/Relationship (Type, Print) Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER 5310 Jenevieve Da Ho, red ordela Ister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. Baltimore National 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility 21. Signature of Funeral Service Licensee rch F. H. West 21215 ade ana wabash grenne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 5day8 Examiner a consequence of): Physician/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 3 by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has blirector, page 2 s 20No 1 ☐ Yes 1 Tyes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 2 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred edicai Certification: Affer Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours att To the Funeral Di completaly filled in to Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, MAY 1

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Ave. Bulhmore

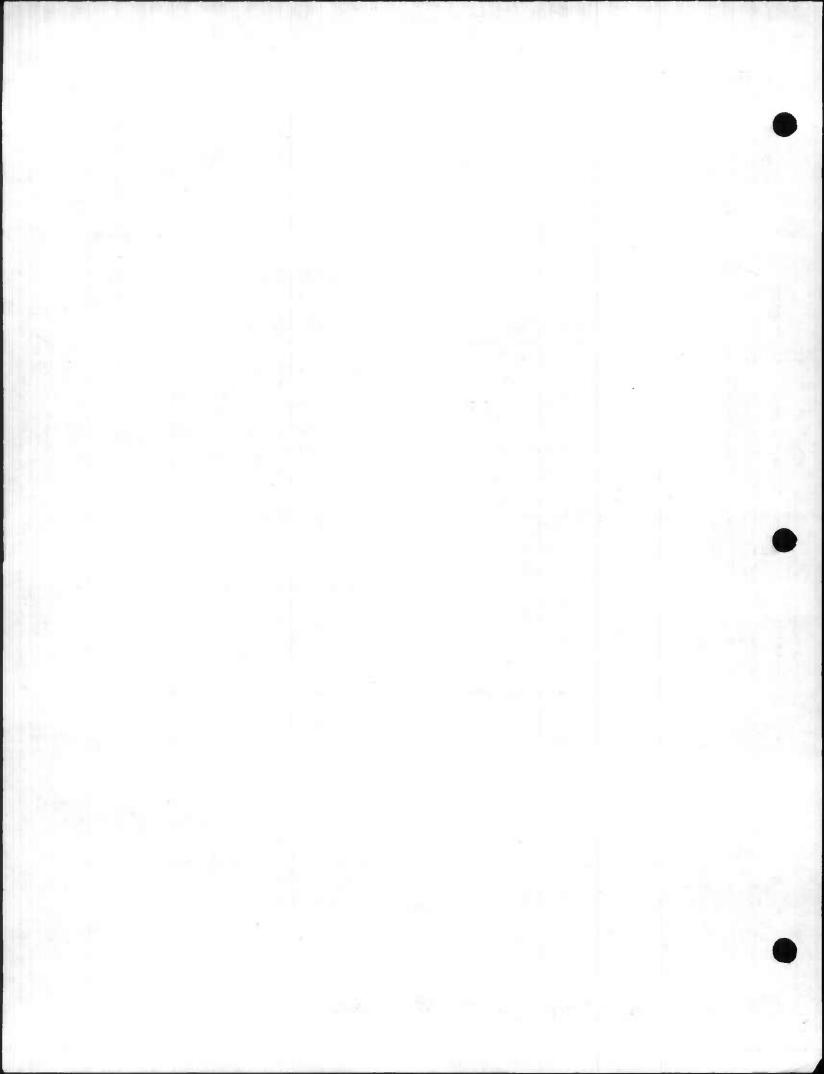
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Bel

32. Registrar's Signature

ved



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Month ! 3. Time of Death 1. Decedent's Name (Figst, Middle, Last) 2. Date of Death **Physician** Brown yes rue /ai · /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1aR4/and el timore 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number 6 Sax Birthplace (State or Foreign Country) **Funeral** 1MM 20 F Months Hours Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Pity Limits 28a-f show Department of Health end Mentel Hygiena.
Important: If Item 27 is marked other than 'natural', or Itema 23a or 28a-f ehov any Injury or other traumatic avant, the Medical Examiner must be notified at 00.09. Maryland Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 V No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 Married 1 Never Married 1 Yes 2 No しってのよりと Baltimore, Maryland 21215-0020 Specify PY 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT μsa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Margary 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Moore - SISTER Danus 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or haart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner the buriel-transit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last and Due to (or as a consequence of): The law requiras thet the death certificate be execu Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eta has been signed by paga 2 should be detac &/on an py 24b. Wara autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy this certificeta has 1 ☐ Yes 2 PNO 1 □ Yas 2 □ No of Attending Physician: eftar death. Director: Aftar this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Panding Investigation Injury 1 TYes 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital within 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

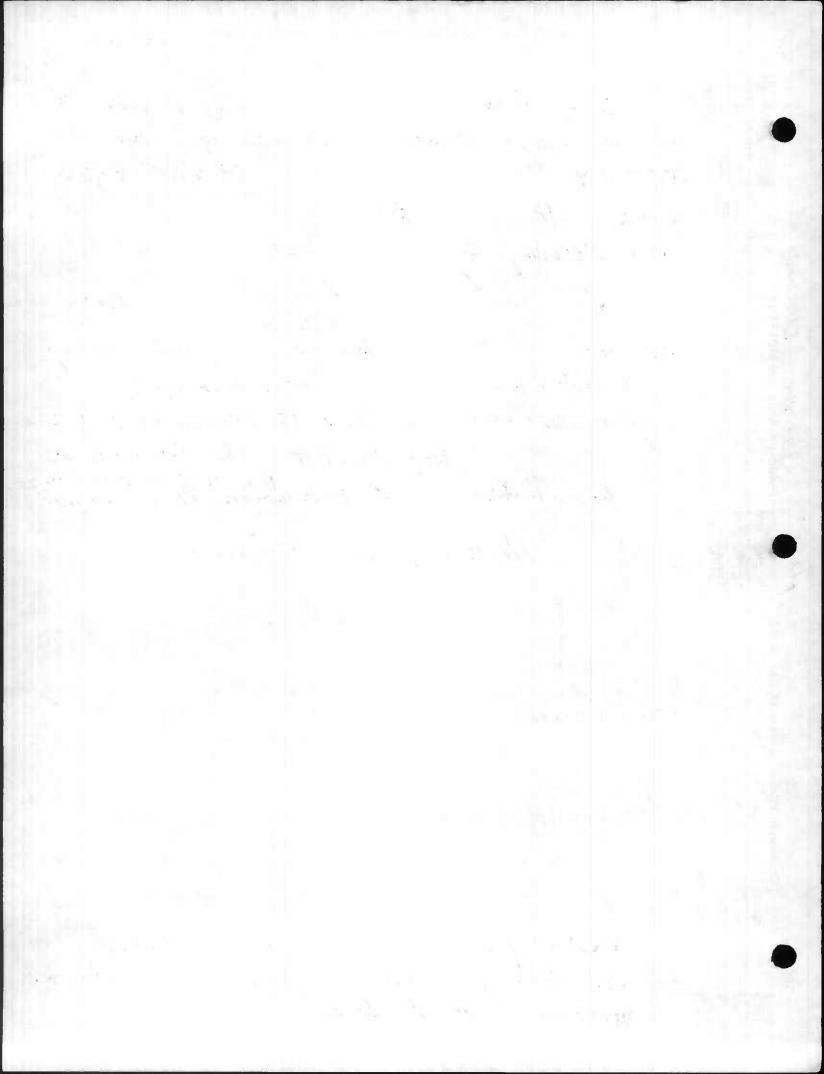
Rypard General

DHMH 16 Rev 6/95

State Registrar 30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

Kenneth 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 AMended#23apt1 c,d perPHYG771 5/17/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1352 Marsha 99 4b. City, Town, or Location of Death 04 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** Baltimore of Univers, ty If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) AUG 9 1943 9. Birthplace (Stete or Foreign 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex 1 M 2 XF Months PENNSYLVANIA 55 172-34-0927 Usua! Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inaide City Limits 1 Yes 2 No Directo MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 224 PINEWOOD DRIVE 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MORTAGE CLERK BANKING 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) MARSHALL CUMBERLAND **JESSIF BROOKS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 224 PINEWOOD DRIVE PASADENA, MD. 21122 ROBERT L. BAIN SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/5/99 METRO CREMATORY INC. BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, MD 21122 23a. Parts. Emer the disease, or shock, or heart failure. List compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one carse on each line. Multisystem Organ Immediate Cause (Final disease or condition resulting in death) Examiner patic Faily Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last PARTIAL HYPERTENSIVE GASTROPATHY Physician/Medical Due to (or as a consequence of): AUTOIMMUNE HEPATITIS/CIRRHOSIS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 2 Q 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy Completed 1 Yes 21 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 PNatural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

physician and the buriel-transit signed by t certificata Hospital or Attending Physician: this Aftar

Physician /Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural" any injury or other traumatic even.

Certification: 24 hours after daath. Medical within 2

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 51001

of Maryland

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

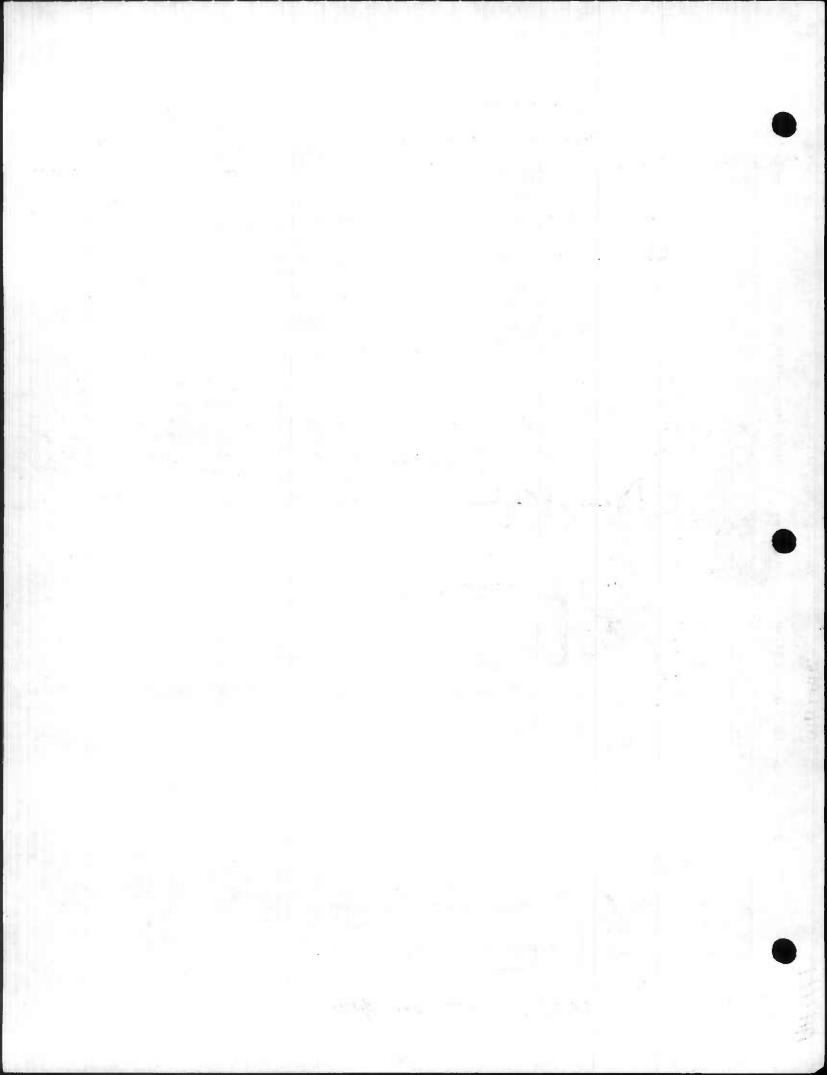
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 9 9 | 5807

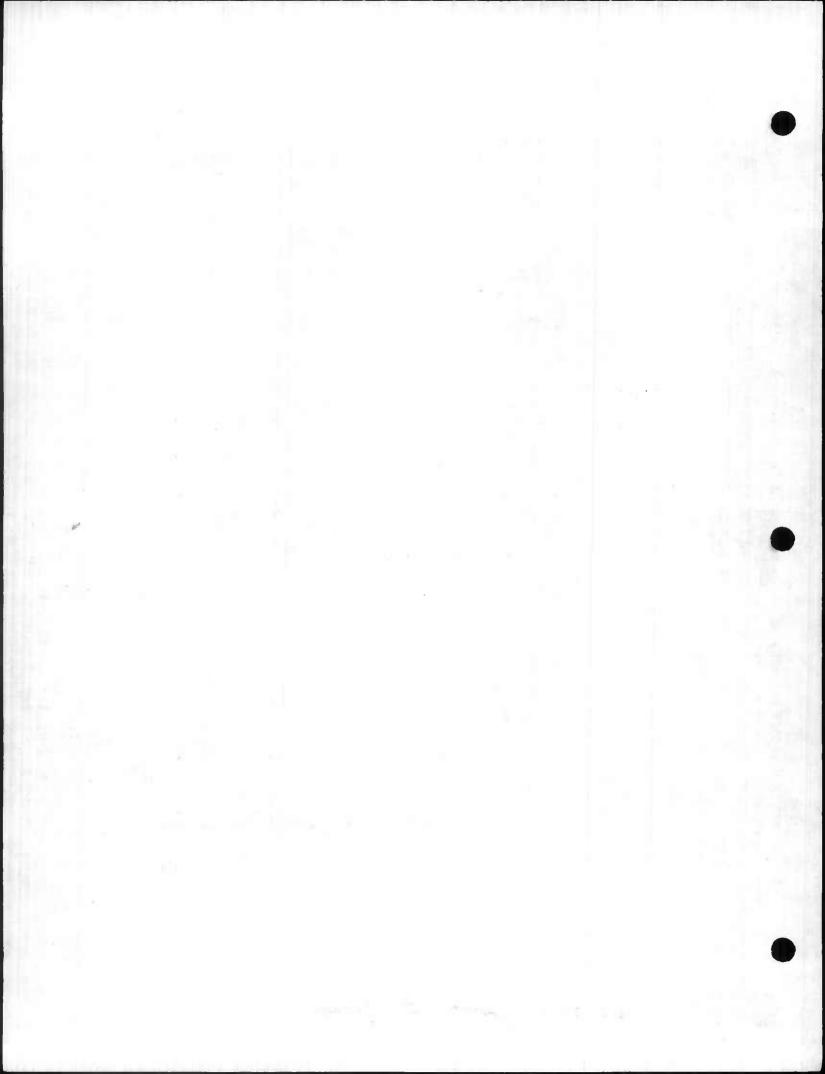
					C	ertifica	te of	Death		R	eg. No.		
	1. Decedent's Name (First, M	iddle, Las	st)							2. Dete of Deet Month	-	Van	3. Time of Death
Physician Medical/	Rodney Cha	rles	Craw	ford						May	15, 19	99	10:55a.m
Examiner	4a Facility Name (If not institt	ution, give	e street an	d number)				4b. City, To	wn, or Le	ocation of Death	4c. Count	y of Death	
	Genesis El	-							OWSO			Balt	imore
Funeral Director	5. Social Security Number 577–70–4040	6. S	ex □XVI2□		yrs. last birthda 48 Yrs.	Month:	or 1 Year Deys		Min.	8. Date of Birth (Month, Day, Apr 10,	Year	Cou	place (Stete or Foreign ntry) nington, DC.
P	Usual Residence of Deceden 10a. State 10b. Cou			10	c. City, Town or	ocation							10d. Inside City Limits
with the Maryland a or 28a-f show Libe notified at Director		N/A				Balti	more	2					1 Yes 2 No
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us sher death vir. or hams 23st Caminer must.			Arme 1-X-1	Decedent Ever of Forces? fes 2 No s, Give or Dates:	r in U,S. 13	Was Dec				ecify Yes or No- Rican, etc.)		ck, White,	can Indien, etc.
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ed within 72 ho ygiens. er than "naturn it, the Medical. Completed	Elementary/Secondary (0-1		Colle	ge (1-4or 5+)		1th (Techn	icia	n	M	edica	al
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and M and M a man	19a. Informant's Name/Relet	ionship (7	Type, Print))	19b. Me	iting Addre	ss (Stree	t end Numb	er or Run	al Route Number	City or Town	, Stete, Zir	Code)
alth a	Kimya D. Cra	wfor	d (Da	ughter	273	4 Wir	ches	ster S	tree	t Baltin	nore, M	faryla	and 21216
Papes 1. ent of He nt: if Berr ry or oth	20a. Method of Disposition 120Burial 2 Cremati 4 Donation 5 Othe				Cob. Ptece of Dis cemetery, co	emetory or	other ple		5/	Dete 21/99	20c. Location Owings		own, Stete
Departm Departm Importa any inju	21. Signature of Funeral Service			0				ess of Fecili	ty Ca	ple Fund	eral Se	rvice	e
	23a. Pert1. Enter the disease	or comp	olications	het caused the	death. Do not e							ırylaı	nd 21215 Approximete
Physician	shock, or heart feilure.	List-only o	one cause	on each line.									Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition		8	AIDS	5							1	YEARS
12	resulting in death)			MULTI	to (or es e cons	N Y S		Λ				3 3	MONTHS
m and fel-transit	Sequentially list conditions, if any, leading to immediate	1	b	-	to (or es e cons			77				1	101017113
g physicie as the bur	Cause (Disease or injury that initiated events resulting in death) Last	1	d	Due	to (or as a cons	equence of):					1	
death e atter ed for u	Part II. Other significant cond	titione co	ontributing	to death but no	ot resulting in the	underlying	CBUSA DI	iven in Pert	1	23h Did to	pacco use co	ontribute t	to the cause of death?
as that the death certigned by the attendin be deteched for use by Physician/N		antiona oc	Authoriting	to count out it	A resulting at the	didenying	cause gi	NOT WIT OIL		1 🗆 Y	1		bably 4 Unknown
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yalclen: The law s certificate has director, page 2										1 🗆 Ye	s 2 No	11	□Yes 2□No
oertificate rector, pag	25. Was case referred to med examiner?	fical						26. Place	e of Deet	h (Check only on	(e)		
	1 Yes 2 No			1 Inpatient	2 ER/Outpati	ent 3 🗆 [JUA		ursing Ho	me 5 Reside	ence 6 🗆 Ot	her (Speci	fy)
is after dash of process of proce	a La receoutin	estigation		Date of Injury Month, Day Ye	28b. Time Injury		28c. Inju Wo	rry et ork?]Yes 2□	No	28d. Describe ho	ow injury occu	rred	
har de ha	3 Suicide 6 Co	uld not be ermined	280. F	Plece of tnjury - puilding, etc. (S	At home, ferm, specify)	street, lecto	ory, office			28f. Location (SI City or Town		ber or Aur	al Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification	29a. Certifier Certification (Check only ane)	fying Phy cal Exam	iner: On the	the best of my he basis of exa menner steted.	y knowledge, deaminetion and/or	eth occurre	d et the ti	ime, date ar opinion, des	nd place, ath occur	end due to the cored at the time, do	ause(s) and mate end ptece,	enner es a , and due t	stated. to the cause(s)
vithin To the	29b. Signature and title of cer	Lilier	3413			2	9c. Licen	se number	7	2	9d. Date şigne	ed (Month,	Day, Year)
->-0	-		_	5	3	16	1	7522	279		5/1=	7/9	9.
	30. Name and address of pers			cause of death	(Item 23a) (Type	Print)	char	cles 5	heet	- Stute 3	300 P	Balt 1	9. MD21201
State	31. Date filed (Mooth, Pay, X	narl		2. Registrar's	Signature 4	1	200 4	//					
Registrar	MATI	0 13	99	1	~	14	MI	V					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Beatrice CARROLL 14th 1999 8.43am. /Medical May 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Commons N/H Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2/3/F 243-03-3935 86 Yrs. 9-16-1912 Director N.C. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits items 23s or 28s-f show ner must be notified at Md N/A Baltimore NXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 3731 Boarman Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No if Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. hours after 1 Never Married 2 Married 6 Black Saltimore, Maryland 21215-0020 1 Yes 20 No Specify: P 3 ☐ Widowed 4 ☐ Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home N/A 10th grade Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
important if flem 27 is marked oth
any leijury or other treumatic event Be Malisa Grav James A. Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Carroll - Husband 3731 Boarman Avenue Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 5-19-99 Balto Co, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 Part1. Enter the disease, or com shock, or heart failure. List only implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, by one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Two Days. Examiner Due to (or as a consequence of) Coronary Artery Disease Years. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the Due to (or as a consequence of): attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. Ē B 1 Yes 2 No 3 Probably 4 Unknown Alzheimers"s Disease Records, à 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 農 1 ☐ Yes 25tNo certificate 1 ☐ Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: ↑ Inpetient 2 EFVOutpatient 3 IDOA To 1 Yes 2 XNo 100 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Athor 1 Matural Attending 5 Pending investigation death. 1 Ves 2 □ No 2 Accident To the Hospital or Attend within 24 hours after deal To the Funeral Director. 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29s. Cartifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 1999. D30469. 14th May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055, Chevrol; et Drive, #Suite 100, Ellicott City, MD 21042. N B Vellanki, 90 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 17 1999 MAN Registrar

AKS



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last 2. Dete of Deeth 3. Time of Death 700 Fecility Neme (If not institution, give street and number) 4b Gity, Town, or Location of Deeth HOME If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. iest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) Days Hours 575-48-911 Usuel Residence of Decedent 1□M 20 F 93 Yrs. May 6, 1906 China 10e. Stete 10b. Count 10c. City, Town or Location 10d. fnside City Limits Baltimore Maryland Towson 1 ☐ Yes 2 XNo 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 810 E. Seminary Ave. 21286 United States 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 3 No if Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Merried 1 ☐ Yes 2 No Specify: Asian 3 Wildowed 4 □ Divorced Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Tin Yuk Lum Shee 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Alsona C. Wong / Daughter 810 E. Seminary Ave., Baltimore, MD 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete Green Mount Crematory 5/17/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Neme end Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Immediete Ceuse (Final diseese or condition resulting in deeth) GASTRIC LYMPHOMA Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown bleeding 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 Yes 2 10 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

2

Lee

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Moulcal Examiner must be notified at

Important: If Item 27 Is marked other than "natural", any injury or other traumatic event. Its Mad eat Ex-

Hygiene.

Peges 1 end 2 should be in nent of Heelth and Mental I

the Maryland

pue

physician s the burial signed by

Physician/Medical by Completed Be Certification: by

P.O. Box 68760. Records, Division of Vital the Hospital or Attending Physician: hin 24 hours efter deeth. the Funeral Director: After this certifica To the Hospital of within 24 hours of To the Funeral D completely filled |

> State Registrar

WENEUSA NAVARRO 31. Dete filed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending Investigation

6 Could not be determined

25. Wes case referred to medical exeminer?

29b. Signeture end title of certifier

19 avandow

1 Yes 2 No

27. Menner of Deeth

1 Naturel

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

32. Registrer's Signeture

28e. Dete of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28b. Time of

Specialis

28c. Injury et Work?

29c. License number

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Dey, Year)

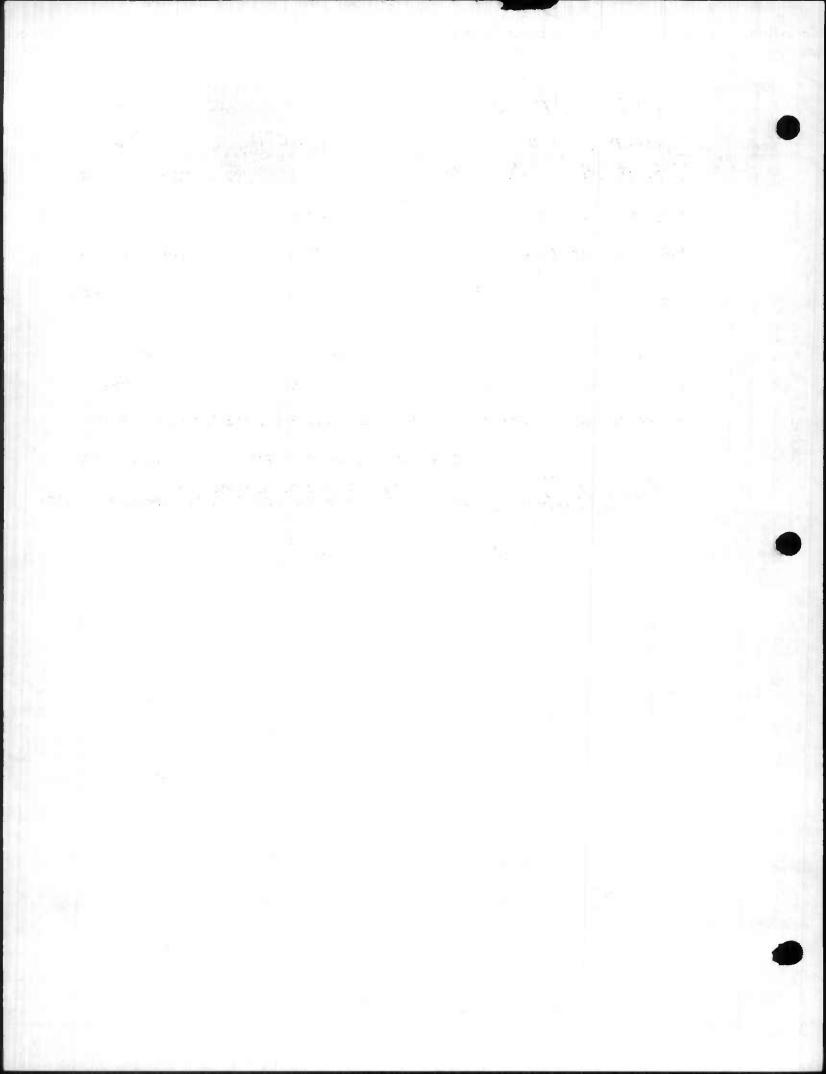
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

100 N. Broadway, Baltimore, Maryland 21231



			Cer	tificate of	Death	ental Hyg	eg. No.	138	10
Physician	1. Decedent's Name (First, Middle, La	St)				2. Dete of Deet Month	h Dey	Year 3. Ti	me of Death
Physician /Medical	Jessi4	Colo JR	7			Nex	-		1:20 PM
Examiner	4a Facility Name (If not institution, giv				lb. City, Town, or Lo		4c. County	of Deeth	
Funeral	5. Social Security Number 6. S 238-80-2366		a. last birthday) Yrs.	If Under 1 Year Months Days	Be 1485 If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day,	Ba (45)	9. Birthplece (5 Country) 948 Mar	State or Foreign
Director	Usual Residence of Decedent	, 30				Augi	250 0,1	340 Mai	yrana
with the Meryland is or 28a-f show the notified it	10a. State 10b. County		ity, Town or Loc						Ide City Limits
vith the Me s or 28a-1 be notified	Maryland	Bal	timore						100 2010
or 2	10e. Street and Number			10f. Zip Code			0g. Citizen of V		
death w	2828 Clifton Av			21216			Jnited :		
Urs efter de or, or item Examination by Fune	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1966		Ves Decedent of H Yes, specify Cubo	lispenic Origin? (Spe an, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)		e - American Ind ek, White, etc. Black	en,
15-00:	15. Decedent's Ed		16e. Deced	ent's Usual Occup	etion during most of worki		16b. Kind of Bu	isiness/Industry	
1 21215-0 led within 72 ho hygiene. Tr. tr. Madical. Completed	(Specify only highest gra	College (1-4or 5+)	life. E	OO NOT use retired	during most or worki	ng .			
CA THE O	12		Upols	terer			Labor		
be filed tal Hygie d other beaut, the	17. Father's Neme (First, Middle, Last))			18. Mother's Neme	(First, Middle, M	Maiden Sumam	(e)	
Maryland of 2 should be file tith and Mental Hy 27 is marked other traumatic event	Jessie David Co	le Sr.			Brilt G.	Buie			
lary	19a. Informent's Name/Reletionship (19b. Mailin	g Address (Street	and Number or Rura		City or Town,	State, Zip Code)	
Nore, Maryland (1995) and 2 should be filed to of Health and Mental Hys If Item 27 is marked other or other traumatic event,	Ms. Reynolds/ Sis	ster	3705	Boarman	Avenue, B	altimore	e. Marv	land 212	215
or other to	20e. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other place		Dete	20c. Location -	City or Town, St	ate
Pages nent of net: If lu	1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				M	ay 21	Sanfo	rd, NC	
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Depariment of the control of the con	I dild St	7)-	31	11 Mount	ain Road,	Pasadei	na, Mar	yland 21	1122
Physician /Medical Examiner	23a. Part 1. Enter the disease, or come shock, or heart takere. List only Immediate Cause (Final disease or condition resulting in death)	0	Meni- (or es e conseq					Interv	eximete al Between t and Deeth
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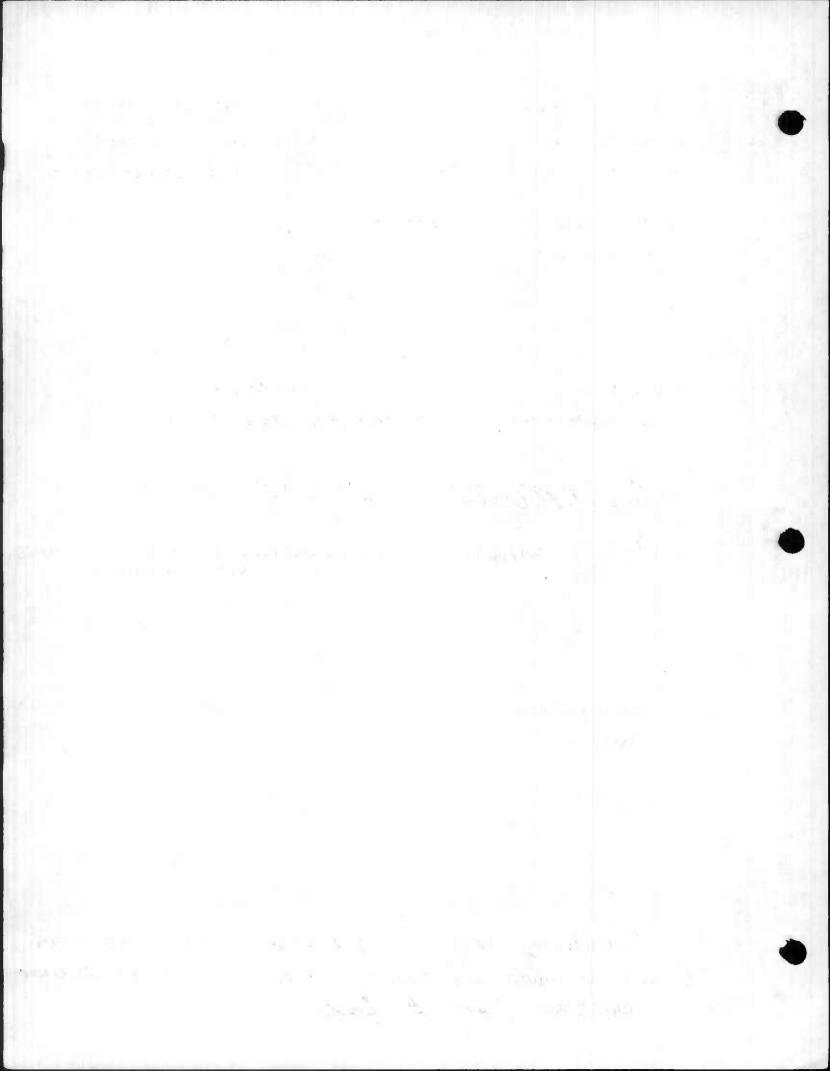
State of Maryland / Department of Health and Mental Hygiene

						Certificate o	f Death	Re	g. No.	15	811
Р	Physic	ian	1. Decedent's Neme (First, Midd	le, Last)				2. Dete of Deeth Month		3. T	Time of Death
	/Medi Exami	cal	Elinore Ma		or)		4b. City, Town, or L	May 8	-	7:	30 A
			3001 Liberty	Parkway			Dundal		Balt	timore	
	Funeral Director		5. Social Security Number 200-12-5166 Usual Residence of Decedent	6. Sex 7. A 1 M 2√2 F	Age (In yrs. lest i	Yrs. If Under 1 Ye Months Dey	s Hours Min.	8. Dete of Birth (Month, Day, May 16,		9. Birthplace (S Country) Pa.	Stete or Foreign
	fand		10a. Stete 10b. County		10c. City, To	own or Location				10d. Inc	side Clty Limits
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	or 28	Director	10e. Street end Number			10f. Zip Code	Э	10	g. Citizen of W	hat Country?	
	23a	ai	3001 Libert	y Parkway			21222		U.S.A	•	
21215-0020	n 72 hours efter death with the Meryland "natural", or liems 23s or 28s-f show safical Evaniner mark be notified at	by Funeral	11. Maritel Stetus 1 □ Never Merried 2 □ Mer 3 □ Vidowed 4 □ Divorced	If Yas Give	N 0 N 0	13. Wes Decedent of it Yes, specify C	of Hispanic Origin? (Sp uben, Mexican, Puerto lo <i>Specify:</i>	ecify Yes or No- Rican, etc.)	Black	- American Ind c, White, etc. hite	ien,
2-0	72 ho	Completed	15. Deceder	it's Education st grade completed)	16	ia. Decedent's Usuel Occ	cupetion	10	6b. Kind of Bus	inass/Industry	
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Maryland	2 0 0 0	Be						e (First, Middle, M		")	
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re,	f Heel f Heel flem 2 other		20e. Method of Disposition	11 / 5011	20b. Piece	of Disposition (Neme of tery, cremetory or other p				City or Town, St	late
Ë	Peges net: If fe		1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S		8 1	o-Washing			Laure	1, Md.	
Baltimore,	emit. Pe bepartmen mportant: ny Injury ince.		21. Signature of Fugeral Service			22. Name end Add		4			
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	0 0 2	Physician/N	Pert II. Other significant condition	one contributing to death	but not resulting	in the underlying cause	given in Pert I.	23b. Did tob	acco use conf	tribute to the c	ause of death?
s, P.O.	requires that the des sen signed by the a hould be detached i	by Phy	CoPD, an	mia, o	lema	ntien, ch	ronic	1 🗆 Yes	2 No	3 Probably	4 Unknown
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ā	E se		/					1 ☐ Yes	2 No	1 🗆 Yes	2 No
5	Physician: The this certificate rai director, page	Be C	25. Wes casa referred to medica examine?	Hospitei:			Whon	h (Check only one			
ō	Phys rthis seal di	: To	1 D es 2 No 27. Manner Death	1 ☐ Inpai		Julpatient 3L DOA	4 LI Nursing Ho	ome 5 Amasiden 28d. Describe how			
0	Attending For death.	tion	1 ENetural 5 ☐ Pendir 2 ☐ Accident investi		ley Year)	Injury V	Vork? ☐ Yes 2 ☐ No				
DIVISION	무류는드	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of II	njury - At home, etc. (Specify)	ferm, street, fectory, office	ce .	28f. Location (Stre City or Town,		r or Rural Route	e Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the bes Examiner: On the basis end menner s	of examinetion e	ge, deeth occurred et the end/or Investigetion, In m	time, date end plece, y oplnion, deeth occur	and due to the cau red et the time, det	use(s) and man te end piece, ar	nar ss stated. nd due to the ci	ause(a)
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	/		Tour Ela	nowlas	M	5 NL	1571.1	2	5-1	1-99	7
	19		30. Name end address of person	who completed causa of	daeth (Itam 23d	(Type, Print)	15764 eDr. Suite	0			^
	10		Tom Edmona	SON 10 91	05 Frai	Klin Sallar	e Dr. Suite	3 D Sal	timare	MD2	1237
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State of Maryland / Department of Health and Mental Hygiene

						rtificate of				Reg. No.	99	15812
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/Med		Laurette A. Da	andeneau						April	25	1999	3:30pm
Exami		4a. Fecility Neme (If not institution, gir	e street end numbe	er)			4b. City, T	own, or Lo	cation of Deatl	4c. Cour	nty of Deeth	
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Funeral			Sex · 7. A 1 □ M 2 ဩ F	Age (In yrs. les		if Under 1 Year Months Devs		r 24 Hrs. Min.	8. Data of Bir (Month, De	th V Year)	9. Birth	olece (Stete or Ford
Director	8	Usuel Residence of Decedent	ILIM ZAF	78	Yrs.				June 2	1, 1920	New H	ampshire
/land		10e. State 10b. County		10c. City, 1	Town or Lo	cation						10d. Inside City Lin
Man a-f el	io	Maryland Anne A	runde1	Seve	erna l	Park						1 ☐ Yes 2 🖾
r 28	rec	10e. Street end Number				10f. Zip Code		1		10g. Citlzan o	f Whet Cou	ntry?
th will	a	24 Truck House Re	oad			21	146			U.S	5.A.	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health end Mentel Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Exporter must be notified at	by Funeral Director	11. Marital Status 1 □ Never Merrlad 2 □ Married 3 및 Widowed 4 □ Divorced	12. Was Deceder Armed Forcas 1 Yes 2 If Yes, Give Year or Dates	s? ∄No		Vas Decedent of f Yes, specify Cul I ☐ Yes 2 🂢 No			city Yes or No Rican, etc.)		ece - Amari leck, Whita, city:Whit	atc.
2 hou	Completed	15. Decedent's E	ducetion	1	16e. Deced	lent's Usuel Occu	pation			16b. Kind of	Bustness/In	dustry
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and and a		Corinne Newton/da	ughter		127 N	listy Co	urt,	Padad	ena, M	2112	22	
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ath certif	Physician/Medical	resulting In deeth) Last	d	Due to (or es								
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Attending Ph ir death. actor: After th by the funeral	Certification:	27. Menner of Death 1 Neturel 5 Pending 2 Accident Investigation		ury ey Year) 28	b. Time of Injury	28c. Inju Wo M 1	ryet rk? ∣Yes 2 🗆		8d. Describe I	low Injury occ	urred	
tal or Attendent setter deat al Diractor: led in by the	Certifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of In building, e	njury - At home tc. (Specify)	, farm, stre	et, fectory, office		2	8f. Location (5 City or Tow	itreet end Nun m, State)	nber or Rura	l Routa Number,
To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edicai	one) 2 Medical Exam	ysicien: To the best niner: On the bests of end menner s	of exemination	dge, death end/or inv	occurred et the ti astigation, in my	me, dete er opinion, des	nd plece, e eth occurre	nd due to the o	euse(s) and r deta and plece	nenner es s e, end dua to	tated. the cause(s)
To To To To To To To To To To To To To T	Σ	29b. Signature end title of certifier	,			29c. Lican				29d. Data sign		
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Sta Registr		31. Dete filed (Month, Dey, Year) MAY 17 19	32. Regist	rer's Signature	<i>b</i> .	Soon	2					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Mildred Esther Fischer May 12 1999 7:00 AM 4a Facility Neme (Il not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 229 Lyndale Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys 1□M 2XF 92 213-26-1467 October 23 1906 Illinois Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 229 Lyndale Avenue 21236 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary State Government 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Butler Jane Dibble t9e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patricia A. Place / Daughter 5101 Meridy Avenue Baltimore, MD 21236 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Bunel 2 ☐ Cremetion 3 ☐ Removel from State 5-17-99 Bloomington, Illinois 4 ☐ Donetion 5 ☐ Other (Specify) Park Hill Cemeterv 21. Signature of Funeral Service Licensee 22. Nome and Address of Feeliny Mitchell-Wiedefeld Funeral Home, Inc. Steven T. Still 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset and Deeth Myocardel INFARCTION

Due to (or es a consequence of):

New Sclerotic Carde o une unha Bipene Immediete Cause (Finel diseese or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert If. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 Ne J Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1 Yes 2 PAN 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 LAK 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner be executed P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be liled within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.
Important: If term 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic svent, the Medical Emeriper must be notified as

Saltimore, Maryland 21215-0020

Physician/Medical Examiner the burial-tran USB 88 signed by page 2 should certificate edical Certification: To this funaral After within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

The law requires that the death certificete Hospital or Attending Physicien:

Records,

Division of Vital

P Be Completed

3 Suicide

4 D Homicide

29e. Certifier

6 Could not be

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

54 Scott Adam Road Suite 202 Cockeysville, MD 21030 Lawrence Boas, M.D.

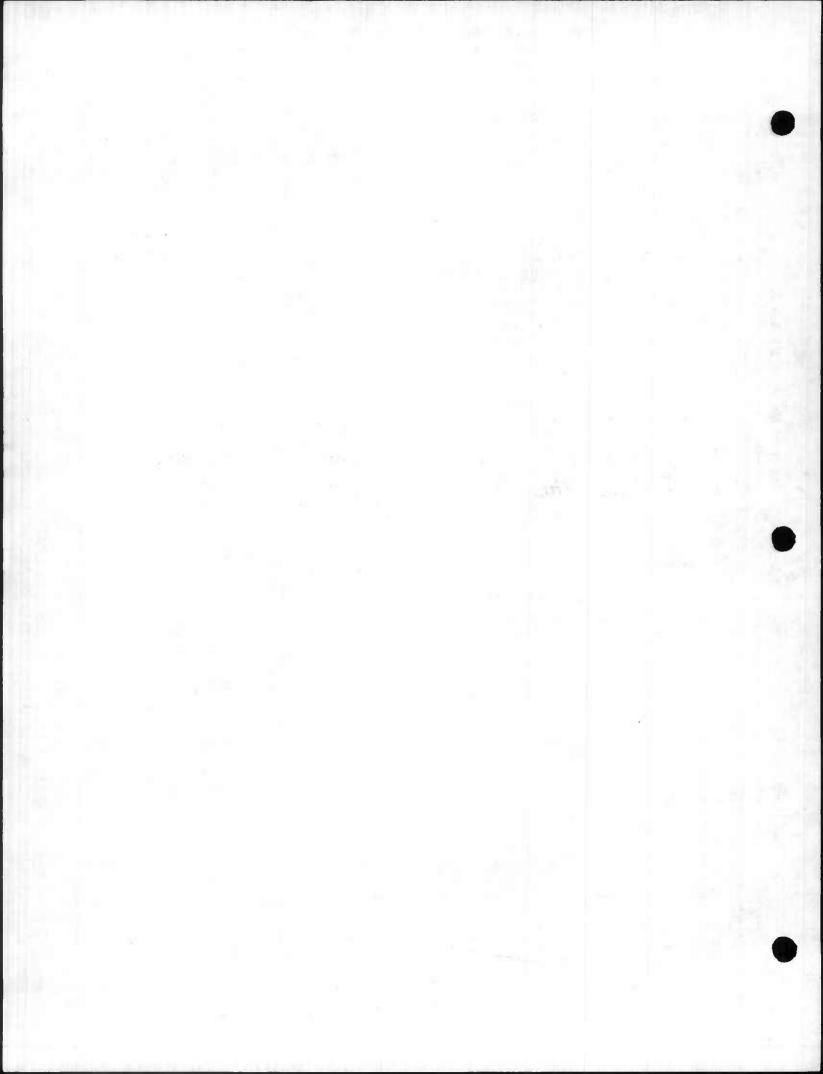
31. Dete filed (Month, Day, Year) State Registrar

MAY 17

32. Registrer's Signeture

DHMH 16 Rev 6/95

To the



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death FRAPPIED 120 MAY 18= 40 PM 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORA HOSPITAL, LOCK RAVEN RAND 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplaca (State or roren, Country) | Months | Days | Hours | Min. | Nov. 29,1928 | Massachusetts MD 21238 SAMMITAN 5. Social Security Number 017-20-1925 Birthplaca (State or Foreign Country) MM 2DF Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 No Md. Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 Pleasant Hill Rd. 21117 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) Marguerite Berthiaume Leo A. Frappied, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dollye E. Frappied - Wife 135 Pleasant Hill Rd., Owings Mills, Md. 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All Saints Cemetery May 17, 1999 Reisterstown, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Service Ling 21117 librards 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MALIGNANT BRAIN TUMOR MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown STROKE 24b. Were autopsy findings available prior to completion of cause of death? INSULIN DEPENDENT DIABETES MELLITUS 24a. Was an autopsy performed? 2/2/No 1 ☐ Yes 2 No 1 Yas 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 120npatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

Examiner certificate be Division of Vital Records. or Attend after death Director: To the Hospital within 24 hours a To the Funeral C

29a. Certifier

(Check only one)

29b. Signature and title of certifier

physician and s the buriel-trans Physician/Medical 88 980 P Completed certificate has Be 10 funeral Certification: death.

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Physician

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Hygiene.

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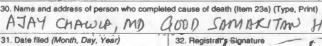
Registrar

DHMH 16 Rev 6/95

State

AJAY CHAWLA, MD 31. Date filed (Month, Day, Year) 32. Registrat's Signature

ATAY CHAWLA



29c. License number 29d. Date signed (Month, Day, Year) -12556

MAY 14, 1999

GOOD SAMBKITAN HOLPITAL LOCKENEW BLAD. BATIMOKEMO

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ETHEL 1999 5:45 am GRAY MAG /Medical 4b. City, Town, or Location Death 4a Facility Nama (If not institution, give/street and number) 4c. County of Death Examiner Church Home Home Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country)
 VA Funeral Days Months Hours 1 M 2 K F 76 Yrs. 07-14-Director 225-18-7825 Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d Inside City Limits death with the Maryla MD NA Baltimore Director ₩ Yas 2 No "natural", or itsms 23s or 28s-f ANG HINGSO PHYSICIAN 10e. Street and Number 10f Zip Code 10g. Citizan of What Country? 1300 East Lanvale Street Apt#225 21213 Funeral USA 12. Was Decedent Ever in U,S.
Armed Forcas?
1 ☐ Yas 🏖 No
If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc after 1 Never Married 2 Married 1□ Yas 2√ No Specify Specify: Black à hould be filed within 72 hours 3√ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Day Care Provider NA Domestic 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 88 Health and Wanter Department of Health and Williams Important: If Itam 27 is marked any Injury or other traumatic ev 2 Patsy Willie Jordan Jackson Baltimore, Mary 19e. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2 1 2 1 3 Pages 1 and 2 Copes 3215 Brendan Avenue Baltimore, Maryland Lavoya 20b. Placa of Disposition (Nama of cematery, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Removal from State Voshell Memorial Gardens 05-18-99 Dundalk, MD Donation 5 Othar (Specify) 22. Name and Addrass of Facility Signal of Funaral Sarvice Licenses Baltimore, Maryland 21202 1101 E. North Avenue WM.C.March FH NX Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immedieta Causa (Final diseasa or condition rasulting In daath) PULMONARY EMBOLISM PAYS Examiner Dua to (or es e consequence ot). Examiner physician and s the burial-transit certificata be executed Sequentially list conditions, if any, leeding to immadiate causa. Entar Undarlying Causa (Diseese or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Dua to (or es a consequança of) 88 P.O. been signed by the s should be detached Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown INFARCTION, DIABETES Records, þ 24b. Ware eutopsy tindings available prior to complation of cause of death? Be Completed 24a. Was an autopsy performed? CANCER BREAST 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case ratarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of Injury (Month, Day Year) 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28a. Placa of Injury - At homa, tarm, street, tactory, office building, atc. (Specify) 4 Homicida 12 Certifying Phyetclan: To the best of my knowledga, death occurred at the tima, deta and placa, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. edical 29a. Certifian (Check only one) 29b. Signatura and titla of captifiar 29c. License number 29d. Date signed (Month, Day, Year) 00052969 MI 30. Name end eddrass of person who completed causa of death (Item 23a) (Type, Print)

A BAKST, MD. 2835 BANESERRY CT. BALTEMOR

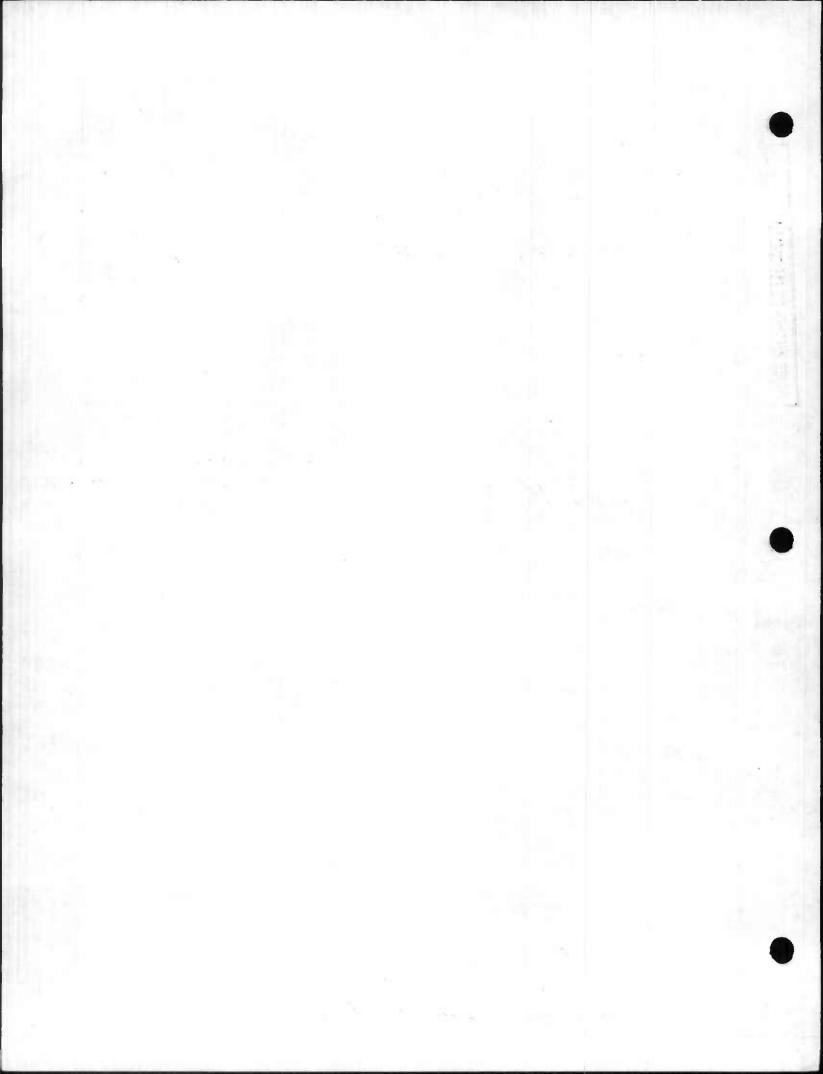
State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year)

32. Registrar's Signature

U. BALTEMORE MD, 21209



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** VIRGINIA ELIZABETH GERDING-KENTNER May 16 1999 08:45am /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner GREATER BATIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 1 Yeer 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign
Country) **Funeral** Months Days Hours Min 1□M 2√ F Yrs. 212-40-0107 100 Director Maryland Aug 25, 1898 Usuel Residence of Dacedant the Maryland r 28a-f show 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo Maryland Baltimore County Cockeysville 10e. Street and Number 10g. Citizen of Whet Country? filed within 72 hours after death with "naturel", or items 23a or edical Examiner must be 300 International Circle 21030 USA Funeral 12. Was Dacadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Datas: Was Decedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status Black, Whita, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Legal 12th Secretary 18 Mothar's Nama /First Middle Maiden Sumama 17. Fathar's Neme (First, Middla, Last) Be Pages 1 end 2 should be John Henry Adams Lillia Stiff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2: Department of Health at Important: If Itam 27 is any Injury or other tratence. John J. Gerding 115 Overcrest Road, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other placa) Date 20c. Location - City or Town, Stata 1 XBurlal 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Dulaney Valley Mem Grdns 5/19/99 Timonium, Maryland 22. Nama and Addrass of Facility e of Futigral Service Linensee 21. Signatu Markers Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death Martin D. Lawson **Physician** ailure /Medical Immediata Causa (Final diseese or condition rasulting in daath) Examiner Examiner mania physician and s the buriel-transit Sequantielly list conditions, if any, leeding to Immadieta causa. Entar Undarlying Ceuse (Diseese or injury thet Initieted events rasulting in daath) Last Dua to (or as a consaguance of): that the death certificete be execu Physician/Medicai Dua to (or es a consequanca of) 89 usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yss 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificate has b 1 Yes 2 No 1 Tyes 2 No or Attending Physician: director, Be 25. Wes casa rafarrad to medical axaminar? 26. Placa of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28d. Dascribe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? Natural 5 Panding after death. Director: Aft 1 ☐ Yas 2 ☐ No invastigation 2 Accidant To the Hospital or Atter within 24 hours after dea To the Funeral Director completally filled in by th 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29e. Cartifiar edicai 29b. Signatura and title 29c. Licanse number 29d, Data signed (Month, Day, Year) 30. Neme and eddrass of person who complated cause of death (Itam 23a) (Typa, Print) 6701 North Charles St., Towson, Maryland 21204 Ganesh Shenoy, M.D.,

State Registrar 31. Data filad (Month, Day, Year)

32. Registrar's Signatura

LLI

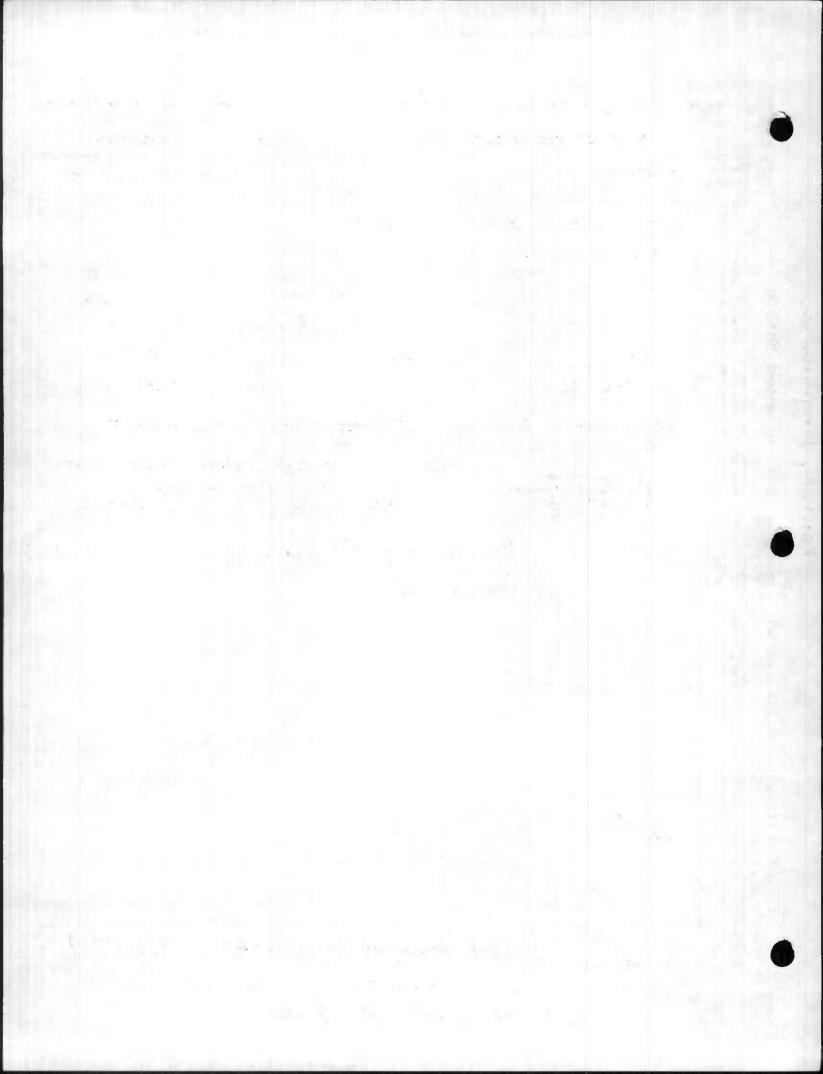
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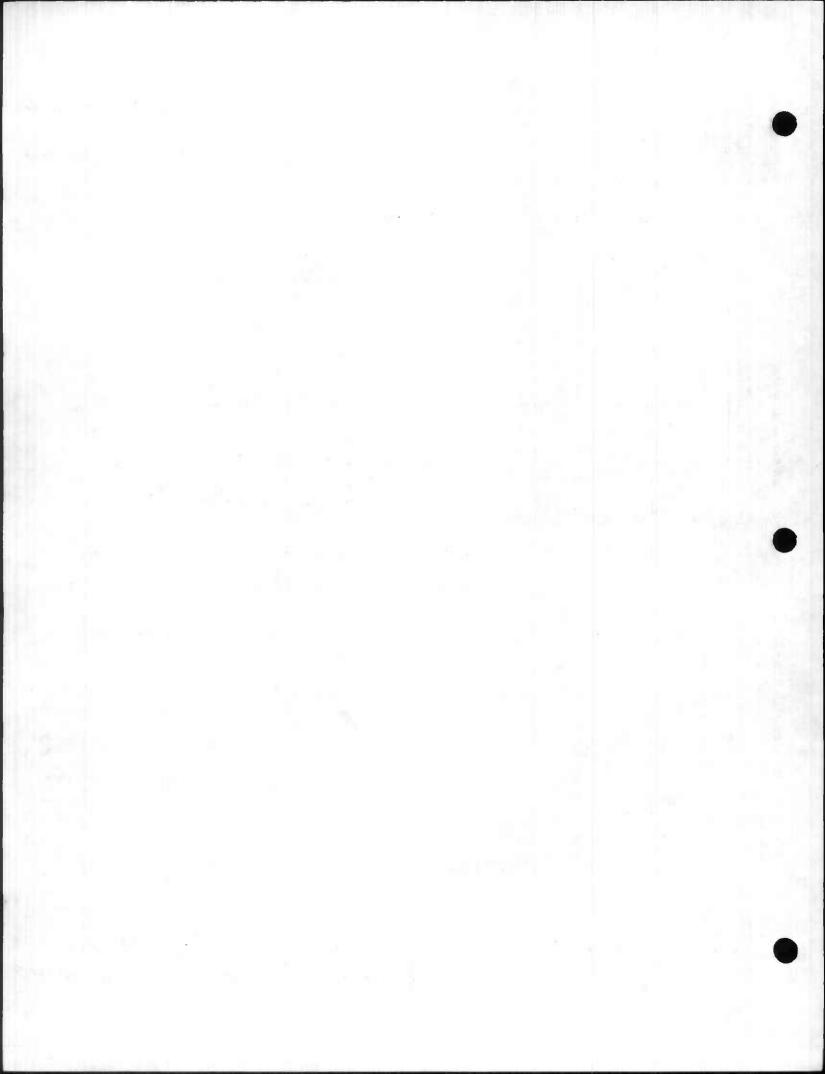
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Division of Vital Records,

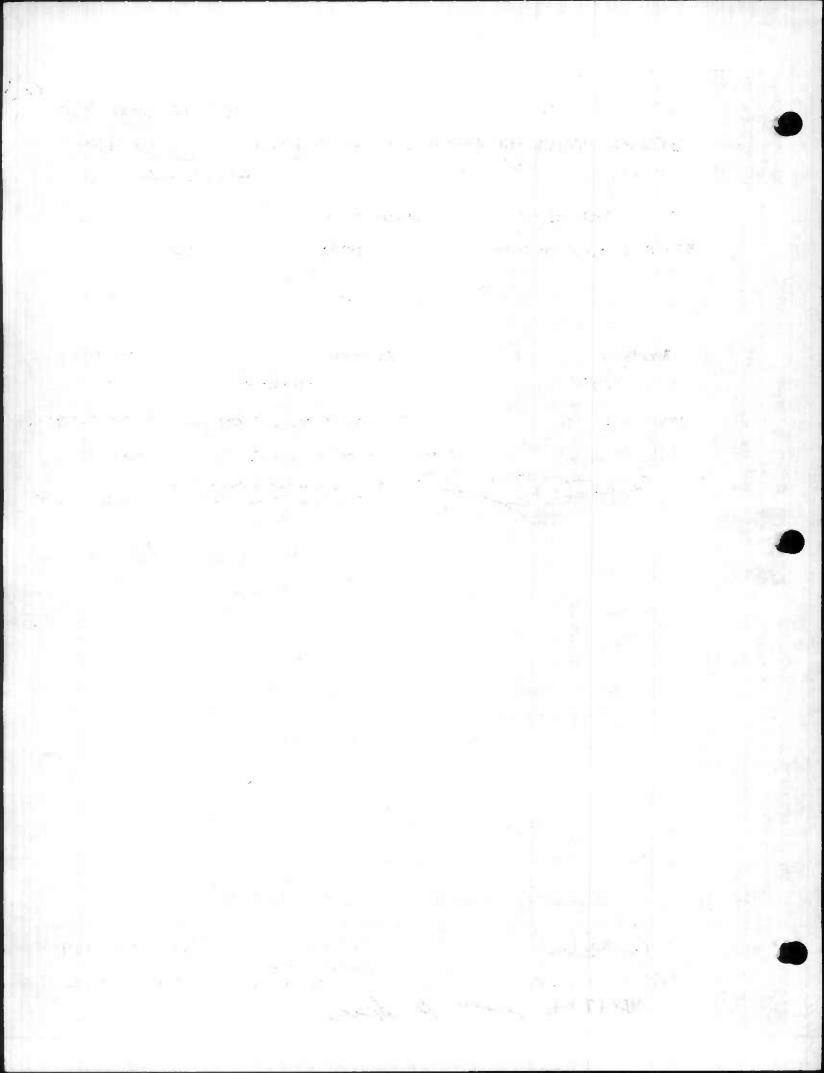


State of Maryland / Department of Health and Mental Hygiene 99 158 17

				Certifica	te of	Death	F	leg. No.		
ician	1. Decedent's Neme (First, Middle, Li	nst)					2. Dete of Dea Month	Day	Year	3. Time of Death
ical	BLANCHE	KIRBY	GAS	SKINS			May	15, 1	.999	10:20 Aus
ner	4a Facility Name (If not institution, gir	The state of the s				4b. City, Town, or	Location of Deeth	4c. County	of Deeth	
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		ITM OFF	n yrs. last bir 37	Yrs. Month	er 1 Yeer s Days	Hours Min		, 1912	Cour	place (State or Foreign htry) yland
	10a. State 10b. County	10	c. City, Town	or Location					1	Od. Inside City Limits
ector	Maryland Howa	rd	Fu.	Lton						1 Yes 2 No
Direc	10e. Street and Number			10f. 2	ip Code			10g. Citizen of	Whet Cour	ntry?
	12401 Lime Kiln	Road			207	759		U.S.	Α.	
by Funeral	11. Merital Stalus 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	r in U,S.		edent of I becify Cub		Specify Yes or No- to Rican, etc.)		ce - Americ ck, White,	
Completed	15. Decedent's E (Specify only highest gr		16a.	Decedent's Us	suel Occup	eation during most of wo	dina	16b. Kind of B	usiness/In	dustry
nple	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retire	d)	нкту			
Con	12 years			Hon	nemak				Home	
Be	17. Father's Neme (First, Middle, Last						me (First, Middle,			
2	Samuel Howard	Kirby				Alic			Herbs	
	19a. Informant's Neme/Relettonship						ural Route Numbe			Code)
	Katherine Storch	(daughter				Lane Co	lumbia,			1045
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐		20b. Piece of cemeter	Disposition (N y, cremetory or	eme of r other ple	ce)	Date	20c. Location	City or To	wn, Stete
	4 ☐ Donetion 5 ☐ Other (Speci	(y) I	Dulaney	Valley M	b moria	al Cardens	5-18-99	Timoni	um, 1	Maryland
	23a. Pert1. Enter the disease, or comshock, or heart feiture. List only			6500 Total enter the mo	York ode of dyi	Road Ba		Maryla rest,	and 2	Approximete Intervel Between Onset and Death
	Immediate Cause (Finat disease or condition resulting In death)	ma	liqua	of A	114	hinda.	10 carlas			Sedden
	resuming in death)	Due	o to (or es e	consequence of	f):				1	1.0
line		b. Atu	erosc	lerotio	_ C	androw	10 culas	disea	9	Jan,
ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			consequence of						
n/Medicai	that initiated events resulting in death) Last	d.	to (or as e c	onsequence of):					
Icia	Part II. Other significant conditions of	contributing to doub but n	at consisting in	the underlying		on in Boot I	22h Did s	ahaasa waa sa	maniferato a	o the cause of death?
by Physician/	ratt. One agricultural conditions t	Contributing to death but h	or resulting in	the underlying	cause gr	ren wi Pert i.	1 🗆 1			bably 4 Unknown
Completed t							24a. Wes of performance perfor	en eutopsy med?	ev	ere eutopsy tindings eileble prior to impletion of cause death?
E							1 U Y	es atino	1[☐ Yes 2☐ No
Be	25. Wes case referred to medical					26. Piace of De	eth (Check only or	ne)	1	
To	examiner?	Hospitel:	2 ER/Ou	tpatient 3 [DOA Oth	ner: 4 Nursing I	Home Pesid	ence 6 Oth	er (Specif	(y)
	27. Manner of Death Natural 5 Pending 2 Accident investigatio	28a. Dete of Injury (Month, Day Ye		ime of njury M	28c. Inju		28d. Describe h			
Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (S		m, street, fecto	ory, office		28f. Location (S City or Tow		ber or Rurz	al Route Number,
edicai	29a. Certifier (Check only one) Certifying Pt 2 Medical Exam	nysician: To the best of m niner: On the basis of exa and minner steted	minetion end	deeth occurre Vor Investigation	d at the til	me, date end piace opinion, death occ	e, end due to the d urred et the time, d	ause(s) and malate end plece,	enner es s and due te	tated. o the cause(s)
W	29b. Signeture and title of certifier			2	9c. Licens	e number 2856		29d. Dete signe	d (Month,	Dey, Year)
	30. Name and address of person who	completed cause of death	(Item 23a) (Type, Print)	-67	the Para	exact fx	Pag 60	Cercles	999 mo2104
State	31. Dete filed (Month, Day, Year)	32. Registrar's	Signeture	1	/					

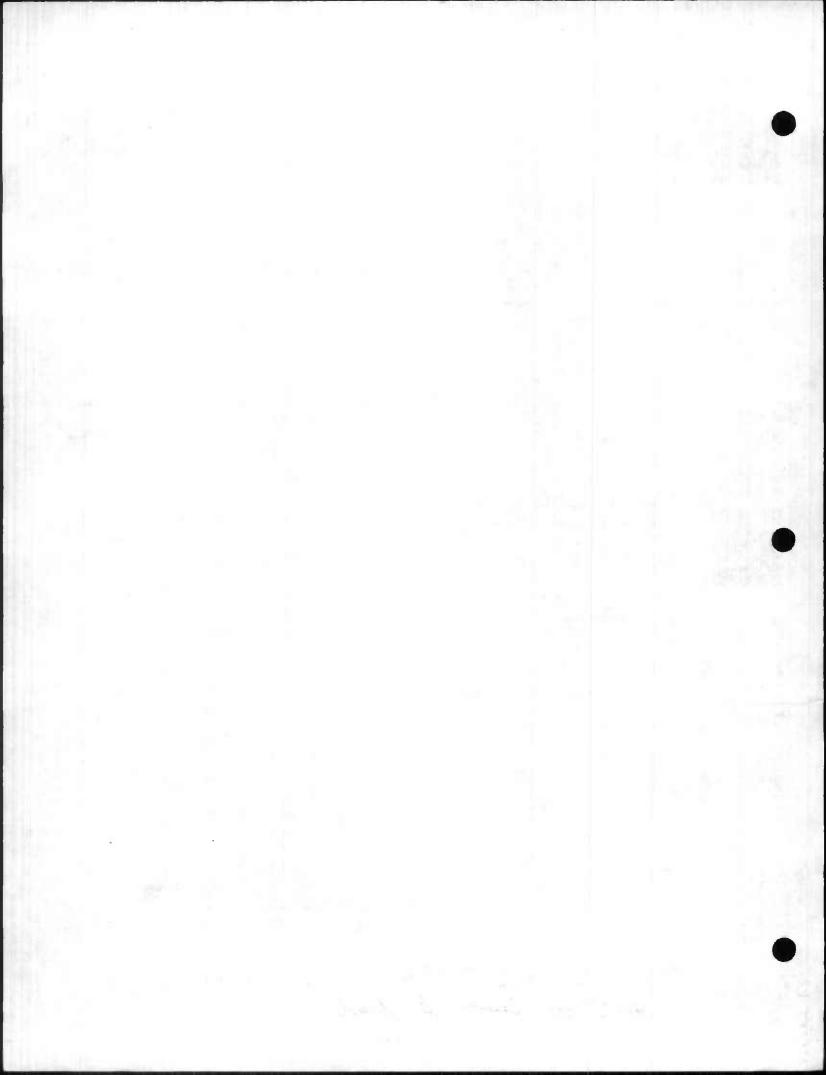


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xamine ineral rector	er	5. Social Security Number 201–05–6014	Anor 9701		st birthday) If t	DR Inder 1 Year oths Deys	RUCKVIL If Under 24 H		MONT	GOME 9. Birthplac Country	24
Mo III		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	1	1			10d.	inside City Lim
San si	Director		delphia			delphi	.a				XXYes 2□!
t be n		10e. Street end Number 5418 North Syca	more Street		10	f. Zip Code 1912	20		10g. Citizen of V	Whet Country	7
	by Funeral	11. Meritei Status 1 Never Merried 2 Men 304Widowed 4 Divorced	If Yes Give	? X 90	If Yes	ecedent of the specify Cub	en, Mexicen, Pu	(Specify Yes or No erto Rican, etc.)		ce - American ck, White, etc y: Wh	
Medical I	Completed	15. Deceden (Specify only higher	st grade completed)		16e. Decedent's (Give kind life. DO N		during most of w	vorking	16b. Kind of B	usiness/Indus	itry
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r traumatic		19e. Informent's Neme/Relations John Glass / S						Rural Route Number			5-2609
othe	1	20e. Method of Disposition		0.01	nce of Disposition	(Neme of		Dete	20c. Location -		
injury or B.		1 Burlel 2 Cremetion 4 Donetion 5 Other (S	pecify)	Holy	Sepulchre			15, 1999	Chelte	enham,	PA
any inj	7	21. Signature of Funeral Service	Victor P.	Doda,	cnar	les L.		Funeral			nd 212
es the bur	dicai	Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underfying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	b	Due to (or e	es a consequence	A ter	7 de	sease			1072
detached for use e	Physician/Me	Pert II. Other algnificant conditio	d	but not result	ing In the underly	Ing cause giv	ven in Pert I.	23b. Dld 1	obacco use co	ntribute to th	e cause of dea
	Dy Pro	Del	Dieisian					10	Yes 2□ No	3 Probab	ly 4 Unkn
2 should	Completed	Uz	may.	Tro	it 1	nfec	tion		en eutopsy rmed?	evelle	autopsy finding ble prior to letion of cause th?
director, page 2		25. Wes case referred to medical						101	/	1 □ Y	es 2 No
I director		exeminer?	Hospitel:	ent 2 TF	P/Outpatient 3[1 DOA Oth	0.00	eeth (Check only o		ar (Specify)	
e funeral		27. Menner of Deeth 1. Neturel 5 Pending investig	28e. Dete of Inju (Month, De	ury 2	8b. Time of Injury	28c. Injur Wor			now Injury occurr		
		3 ☐ Suicide 6 ☐ Could n	and 200. Piece of in	jury - At hom tc. (Specify)	e, ferm, street, fe	ctory, office		28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rural Re	oute Number,
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pletely filled in by the		29a. Certifier 1 Certifying	phyelcian: To the best examiner: On the basis of end menner st	of examinetion	edge, deeth occu n end/or investige	red et the tin	me, dete end plea pinion, deeth occ	ce, end due to the courred et the time, of	ceuse(s) end me dete end place, o	enner as stete end due to the	d. e ceuse(s)
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State of Maryland / Department of Health and Mental Hy	ygien

GE ALE	XANDER HYNSON		Cei	rtificate	e of Death	,	Reg. No.	9 1	5819
D1	1. Decedent's Neme (First, Middle, L	ast)				2. Date of Dea	ith	Veer	3. Tima of Death
Physician /Medical		George Ale	exander	Hynso	n III	MAY]	.5, Dey 1999	Yaer	0325 AM
Examiner	4a Facility Name (If not institution, gi	ve street and number)				Location of Death	4c. County	of Deeth	
	1523 HARFORD S				Edgewoo		HAI	RFORD	
eral ctor	170-58-3445	Sex 7. Age (In 2 ☐ F 2 ☐	yrs. last birthday) Yrs.	If Under 1 Months	Year If Under 24 Hr. Days Hours Mir		7 Year)	9. Birthple Counti	PA
y Funeral Director	Usuat Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10	d. Inside City Limits
6			Baltimor					1.0	1 ☑ Yes 2 ☐ No
Director	Md NA		Daitillor	10f. Zip (Code	1	10g. Citizen of \	What Count	**
arai Di	17 West 24th St			2	1211		USA		
by Funeral	11. Merital Status 1 \(\times \) Never Merried 2 \(\times \) Married 3 \(\times \) Widowed 4 \(\times \) Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:			ent of Hispanic Origin? (fy Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, atc.)		e - America ck, White, e v: Blac	tc.
e e	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	dent's Usuel	Occupation k done during most of wo	orkina	16b. Kind of Br	usiness/Indu	ustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)					Agricu	1+	1
ဝိ	12th grade	NA	CI	erica	1		-		1
8	17. Father's Neme (First, Middle, Las					me (First, Middle,	Maiden Surnen	10)	
2		ER HYNSON, JI			SHARON				
	19a. Informant's Neme/Relationship				(Street and Number or F				Code)
	Sharon J. Hynson				msford Circ	T			
	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Speci		Plece of Dispo cemetery, cred	netory or off		Date 5-19-99	Phila,		vn, Stete
	21. Signature of Funeral Service Lice	nsee A	22	March 4300	Address of Facility F/H West	enue Ba			21215
ledical Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	to (or es e conseq	115-					N.
Physician/M		d			427			t	1.5
	Part II. Other significant conditions	contributing to death but no	at resulting in the u	nderlying ca	use given in Pert I.	23b. Did t			the cause of death ably 4 Unknow
Completed by							en autopsy med?	ava	re autopsy findings ilable prior to apletion of cause
dmo						408	o		eath?
	25. Was case referred to medical	1				HEN		159	Yes 2□ No
o Be	examiner?	Hospitel:			Othor	eth (Check only o			
-	27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatier		4 Unursing	Home 5 ☐ Resid			AT SCENE
tion	1 Neturat 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	м	lc. Injury at Work? 1 ☐ Yes 2 ☑ No	1	rect :	shot	
Certification:	3 Suicide 6 Could not to determined	28a. Ptece of Injury - building, etc. (S	At home, ferm, str pecify)			28f. Location (S City or Tow	treet and Numb	- 0	Route Number,
	29a, Certifier 1☐ Certifying P	hysician: To the best of m	Y LEX y knowledge, death	occurred e	t the time, date and place	e, end due to the	cause(s) and me	50, enner as sta	nted.
edical	(Check only one) Medical Exa	miner: On the basis of exa and menper steted.	minetion and/or in	vestigation, i	in my opinion, deeth occ	urred et the time, o	date end plece,	end due to	the cause(s)
Σ	29b. Signatura and title of certifier	W/		29c.	License number		29d. Date signe		
	7	16/			O.C.M.E		MAY	15,	1999
71	30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)					
	Dania R	Powler			eet, Baltim	ore, Mar	yland 2	1201	
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signeture	10-	11				
State Registrar	MAY 17 199	9 Jenes	0.	door	2				



State of Maryland / Department of Health and Mental Hygiene 9 9 | 582 |

				Ce	rtifica	te of	Death		R	eg. No.	1		3m ()
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/Medical	Rutt	E.		fug	HE	2.			05	13		7.	25p
Examiner	4e Fecility Neme (If not institution, git Long view N			~			Mane	ches			rroll		
Funeral Director		Sex 7. A 1 □ M 2 💢 F	ige (fn yrs. la 75	st birthdey) Yrs.	Months	Deys Deys	If Under Hours	24 Hrs. Min.	8. Dete of Birth (Month, Day Feb. 2)	Year 1924	9. Birthpi Count Mary	Pand	le or Fore
*	Usuel Residence of Decedent 10a. Sfete 10b. County		10c City	Town or Lo	ncation						11	nd Inelde	City LIm
or 28s-f show be notified at Director	Md. Carroll			nches							,		es 2
ect ect	10e. Sfreef end Number					o Code		_	1	Og. Citizen of V	What Coun	Inv?	
r frems 23s or 28s-f show inner must be notified at Funeral Director	3332 Main St				1	2110				U	S.A.		
or to the Examples	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceder Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes	?] No				lispenic Ori an, Mexicar Specify:		ecity Yes or No- Rican, etc.)	Blee	e - America ck, White, o	etc.	
ygiene. rt, tra Med callex. Completed by	15. Decedent's E (Specify only highest gr			16e. Dece	dent's Usu	el Occup	ation during mos	t of work	ina	16b. Kind of B	usiness/Ind	lustry	
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Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any Injury or other traumatic event, the Mental and the To Be Comp	20e. Method of Disposition Duriel 2 Cremetion 3 [4 Donetion 5 Other (Speci		Cel	netery, cre	metory or	other ple		y 17		20c. Location -			
Departmen Important: any Injury	21. Signature of Funeral Service Lice	hardt	-	2					Chapel n Rd., (Owings 1		2111 . Ma	•
hysician /Medical xaminer	23a. Pert1. Enter the disease, or con shock, or heart failure. List only Immediate Ceuse (Finel disease or condition resulting in death)	Θ	Pu Due to (or	Lm es a conse	quence of	7	حس						Betweer nd Deett
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hould be									24e. Wes e	en eutopsy med?	COI	ere autop eilable pr apletion deeth?	sy findin ior to of cause
s cartificeta has t director, paga 2 s									1 🗆 Y	es 203-No			2 No
artificet actor, p	25. Was case referred to medical						26 Place	of Deat	h (Check only or				.,,
this cartific ral director, TO Be	examiner? 1 Yes 2 No	Hospital:	tient 2 E	R/Outpatie	nt 3□ □	OA Ott			ome 5 Reside		er (Specify	()	
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within 24 hours after death. To the Funeral Director: After t completaly filled in by the funeral Medical Certification:	3 Sulcide 6 Could not be determined	286. Pieca of I	njury - At hom etc. (Specify)	ne, ferm, st	reet, facto	ry, office			28f. Location (S City or Town	treet end Numb n, State)	oer or Rura	l Route l	lumber,
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s ⊢ ō	> goenno	nddli	to			DZ	540	+ 3		5/10	+/9	S	
	30. Name and address of person who	completed cause of	death (Item 2	23e) (Type,	Print)	. 6	2erd	1,)	estinin	ster,	mal	71	157
State	31. Dete filed (Month, Dey, Year)	32. Regis	trar' Signatu	Ire -	4	1	n. V	/		,			

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permit.

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funeral director, page 5 should be

the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal.

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s certificate has been s th the State Dept. of H

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DIRECTOR: /

Suresh A.

31. DATE FILED (Month, Day, Year)

After death

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	0
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOHNSON HAZEL may 11:25 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 579-18-7954 DAYS MONTHS HOURS 1 M 2 F FEBRUARY 16, 1900 Se. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BRADFORD DAKS MSG. 4 REHAB DIRECTOR CENTER MARYLAND CLINTON PRINCE GEORGE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Prince Georges Clinton 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7520 Surratts Rd 20735 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

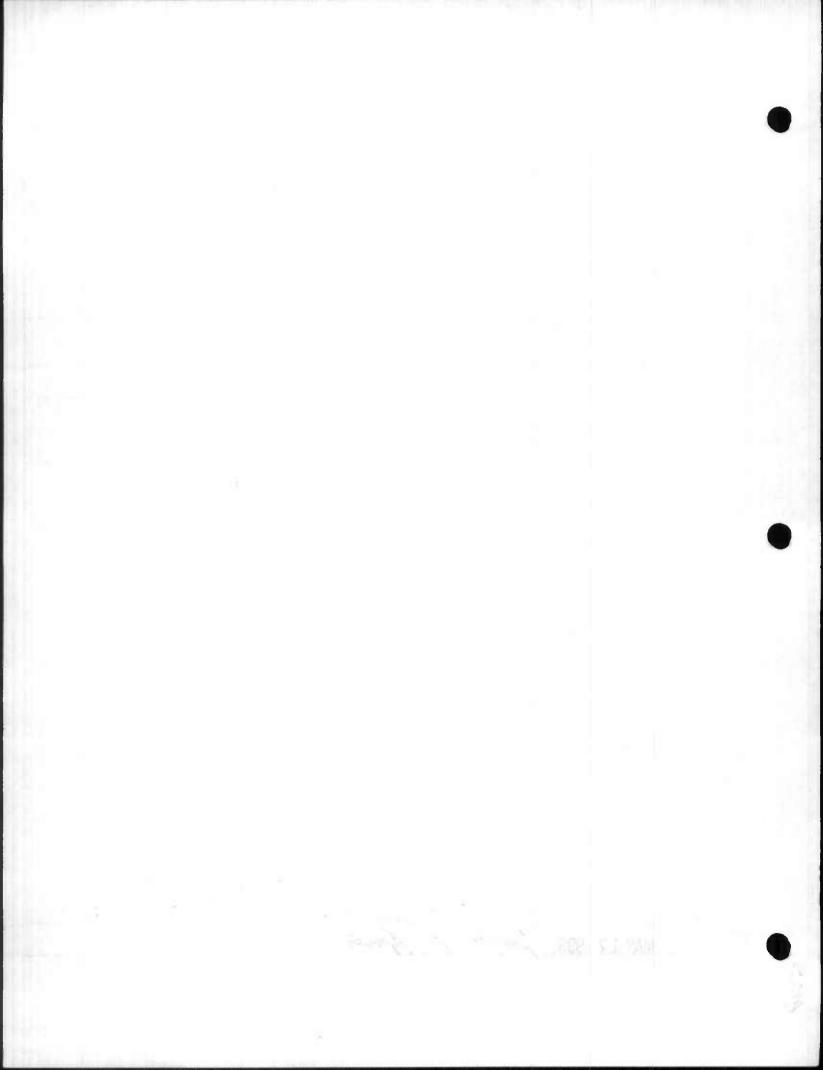
1 YES 2 X NO Specify: 1 Never Married 2 Married BY IF YES, GIVE WAR OR DATES Specify: 3 🔯 Widowed 4 🗌 Divorced **Black** COMPLETED 10e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12th Babysitter Private once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) ti Arthur Weeks Nettie Smith notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avele A. Johnson Daughter Parkwood Pl. NW. 1434 Washington, DC 20010 the medical examiner must be 20s. METHOD OF DISPOSITION
1 © Burlel 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Glenwood Cemetery 5/13/99 Washington, 21. SIGNATURE OF PURE PAR SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dudley Funeral Home Edward Dudley 3200 Rhode Island Ave., Mt. Rainier, 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory strest, Approximats shock, or heart feilure. List only one ceuse on sech line. Interval Between IMMEDIATE CAUSE (Finei Onset and Death disesse or condition resulting in death) CONGESTIVE
DUE TO (OR AS A CONSEQUENCE OF): 2.3mo event. DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 70 shows any injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO sepas COMPLETION OF CAUSE 1 YES 2 NO Anomio 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 Nursing Home 5 - Residence 8 - Other (Specify) 1 TES 2 DINO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 0 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER
(Check aniv. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner se stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE D46478 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32. REGISTRAR'S SIGNATURE

Partelino

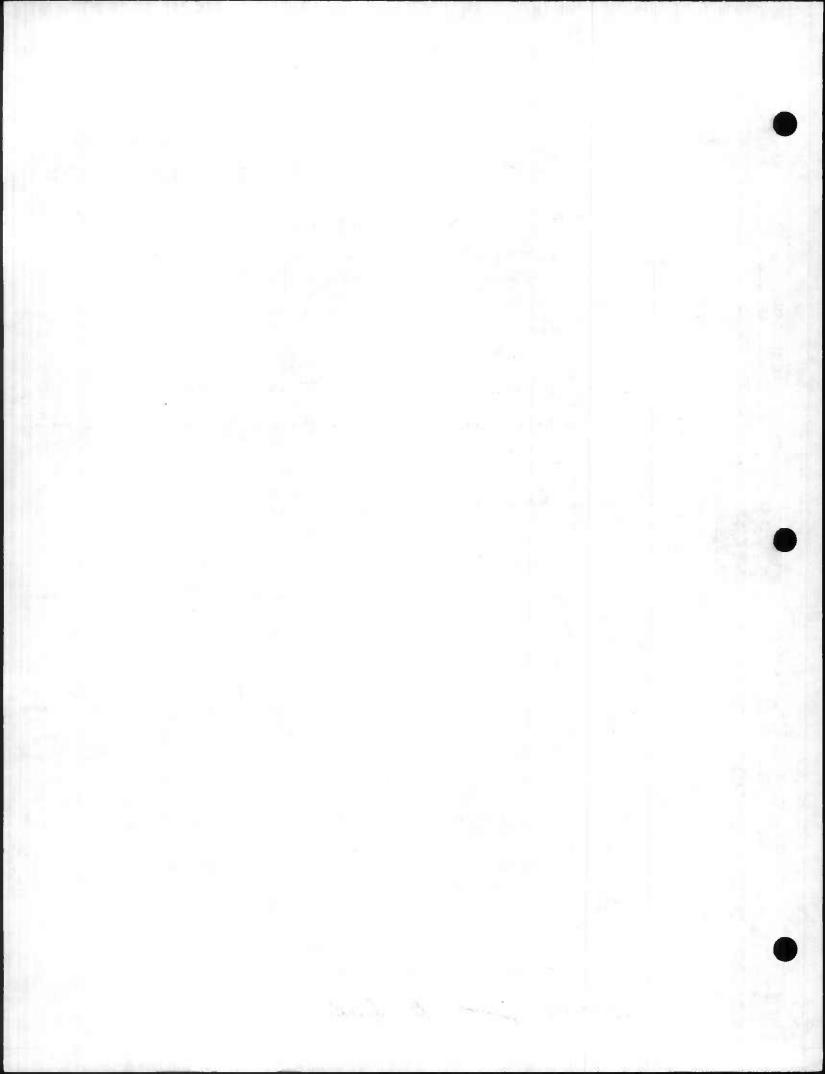
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner 4a Fa	roedent's Name (First, Middla, La: Tama qu	st)							
Examiner 4a Fa	1001100700	10 IMAY	Son			2. Date of Dea Month	Day	Year /	Time of Deeth
	acility Name (If not institution, give				4b. City, Town, or L	May ocation of Death	4c. County	of Death	um
	Sinui Hosi	ostal			Balhma	re	NA	+	
Director 21	cial Security Number 6.5 4 - (2 - 04 (3) 1 Residence of Decedent	ex 7. Age	(In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Sep. Z			State or Foreign
10a. S	-		10c. City, Town or	Location				10d. In	side City Limits
10e. S	UD NA		Dalt	IMORE				1)	Yes 2□No
ther deeth with the Marylan the Coest with the Marylan that Tall the Thermal Director	Street and Number Park	- Heigh	ts Ave	10f. Zip Code 212	15		10g. Citizen of V		
by 13	larital Status Newer Married 2 Married Widowed 4 Divorced	12. Was Decedent En Armed Forces? 1 Yes 2 NAK If Yes, Give Year or Dates:	ver in U,S. 1	3. Wes Decedent of I If Yas, specify Cub 1 Yas 2 No		ecify Yes or No- Rican, etc.)	Specify	a - American Ind ck, White, atc.	lian,
Eler	15. Decedent's Ed (Specify only highest gra mentary/Secondary (0-12)	ucation de completed) College (1-4or 5+	(G	cedant's Usual Occupive kind of work done a. DO NOT use retire M 0 (0 yel)	pation during most of work d)	ing	16b. Kind of Bu	usiness/Industry	UNK
D H 17. Fa	ather's Name (First, Middle, Last)	ohoson			18. Mother's Nam	e (First, Middle,		pa)	
- 5975 11	Informant's Name/Relationship (1) Awa A - Do Method of Disposition Burial 2 Cremation 3 D	10500 -D	20. 52 20b. Place of Di	ailing Address (Street 38 Vark sposition (Nama of cramatory or othar pla	Heights	al Route Numbe	belto.	State, Zip Code City or Town, S	1215
□ .532 —	□ Donation 5 □ Other (Specify counture of Funeral Service Licen		Cedar	22. Nama and Addre	ess of Facility FUNERAL	19-99 U	Hone !	Arundel	Co, red
23a.	Part Enter the disease, or compands, or heart failure. List only	plications that caused the	he death. Do not	enter tha moda of dyi	ng, such es cardiac	or respiratory en		Ho, ma	coximata val Between
Physician /Medical Immedises	ediate Cause (Final use or condition ting in death)		,	hemovrh				Onse	day
			ue to (or as a con	sequence of):	tr :			1	1a
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	entially list conditions, r, leading to immediata e. Enter Underlying e (Disease or injury	C							
	nitiated events ling in death) Last	d	ue to (or as e cons	sequence of):					
S de stranding de	. Other significant conditions co	ontributing to death but	not resulting in the	a undarlying causa gir	ven in Part I.	23b. Did to	obacco use co	ntribute to the o	cause of death?
v requires that the death cariff been signed by the strending should be deteched for use a letted by Physician/Me	polysubstan	no abusi	2			101	'es 2□No	3 Probably	4 Unknow
rector, page 2 should be conflicted by S. S. S. S. S. S. S. S. S. S. S. S. S.		-,				24a. Wes a perfor		available	ion of cause
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S color of axe	/as case referred to medical caminer?	Hospital:		Sint of Doa Oil	26. Place of Deet				
D THE STATE OF THE	Yes 22 No	28a. Data of Injury (Month, Day	2 ER/Outpa	tient 3LI DUA	4LI Nursing Ho	oma 5 Resid			
ation at the	Natural 5 ☐ Pending ☐ Accident investigation		Year) Injur		rk? Yas 2□No				
Lei or Attending P Lei or Attend	☐ Suicide 6 ☐ Could not be detarmined	28e. Place of Injurbuilding, etc.	y - At homa, farm, (Specify)	street, factory, office		28f. Location (S City or Tow		er or Rural Rout	te Number,
the Hospi in 24 hours the Fune the Fune the Fune (4)	one) 2 Medical Exam	raician: To the best of iner: On the basis of e and manner state	xamination and/or	investigation, in my o	opinion, death occur	red at the time, o	late and place,	and due to the c	
29b. S	Signature and title of certifier			29c. Licens				d (Month, Day, 1)	(ear)
DV	ame and address of person who of MFEU 2 (and address of person who of the and ess of person who of the address of person who of the address of the add		Belved	oe, Print) exc Are	Brehn	nome n	10 21	215	

MAY 1 7 1999



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

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			Certificate C	Dealli	Reg	3. No.	
Physician /Medical	1. Decedent's Name (First, Middle, i		John	150N	2. Date of Death Month	Day Year 13 1999	3. Time of Death
Examiner	4e Fecility Name (If not institution, g JOHNS HOPK	N3 HOSPITA	L	BAUTIN	IORE	4c. County of Dea	
Funeral Director	5. Social Security Number 216-58-4706 Usuel Residence of Decedent	Sex 7. Age (In yrs. le	Yrs. If Under 1 Yes Months De		8. Date of Birth (Month, Day, Y	(ear) 9. Bir	tholace (State or Foreign buntry) Md
28a-f ahow notitied at rector	10a. Stete 10b. County	VA Ba	Town or Location				10d. Inside City Limits
her met be notited Funeral Director	10e. Street and Number 4406 Falls	bridge Drie	101. Zip Cod	4211	100	Citizen of What Co	ountry?
Example m by Funer	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Yes, specify C	of Hispanic Origin? (Sp cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Bleck, Whit Specify: 2	
vent, the Healcal E	(Specify only highest g Elementery/Secondary (0-12)	Education	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use rei	ne during most of work tired)	sing 16	St. Kind of Business Bildle	andustry Heat
B .	17. Father's Name (First, Middle, La	/	V 30001 C		Johnso		
ry or other traumatic	20a. Method of Disposition 1 Burial 2 Cremetion 3	Uy - Mb Hh ls 20b. Pts ce	19b. Mailing Address (Str. 4406 Fox ace of Disposition (Name of metery, cremetory or other)	11s bridge	Drive &	City or Town, State, 15 C B 16 Location - City or 17 Anday	elto, md
any injury	21. Signature of Funeral Service Lic	ensee	2. Name and Ad	dress of Fecility H West Wahash	do me	Ba 140	mel ziris
loion	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. y one cause on each line.	Do not enter the mode of	dying, such as cardiec	or respiretory erres	it,	Approximete Interval Between Onset and Daeth
ician dical niner	Immediate Cause (Final disease or condition resulting In death)		SSPIRATORY as a consequence of):	DISTREY	5 SYNT	DROME	21 DAYS
of or use es the buriel-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. THEUMOCYS Due to for c. ACQUIRED 10			YNDROM	-	35 DAYS 4 YEARS
	Part II. Other significant conditions	contributing to death but not resul	ting in the underlying cause	given in Pert I.	23b. Did tob	scco une contribute	to the cause of death
d be detached for	BILATERAL	PHEUMO THO	RAX		1 🗆 Yee	2 No 3 P	robably 4 Unknow
2 shoul					24a. Wes an performe	ed?	Were eutopsy findings eveilable prior to completion of cause of death?
rector, page Co	25. Was case referred to medical			26. Place of Deal	1 ☐ Yes	/	1 ☐ Yes 2 ☐ No
al direct	examiner? 1 Yes 2 No		H/Outpatient 3LI DOA		ome 5 Residen	ce 6 □Other (Spe	ocify)
After	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, Day Year)	M 1	njury at Nork? Yes 2 No	28d. Describe how		
To the Funeral Director: completely filled in by the Medical Certifical	4 Homicide determine	28e. Place of Injury - At hon building, etc. (Specify)	ne, term, street, fectory, offi	Ce	28f. Location (Stre City or Town,	et and Number or R State)	urai Houte Number,
plately fill edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ext	hysician: To the best of my know iminer: On the basis of examinetic and manner steted.	ledge, death occurred at the on and/or investigation, in m	time, date end place, y opinion, death occur	end due to the cau red at the time, date	se(s) and menner a e and piece, and du	s stated. e to the ceuse(s)
To To Com	29b. Signeture and title of certifier			ense number	290	d. Date signed (Mon	th, Day, Year)
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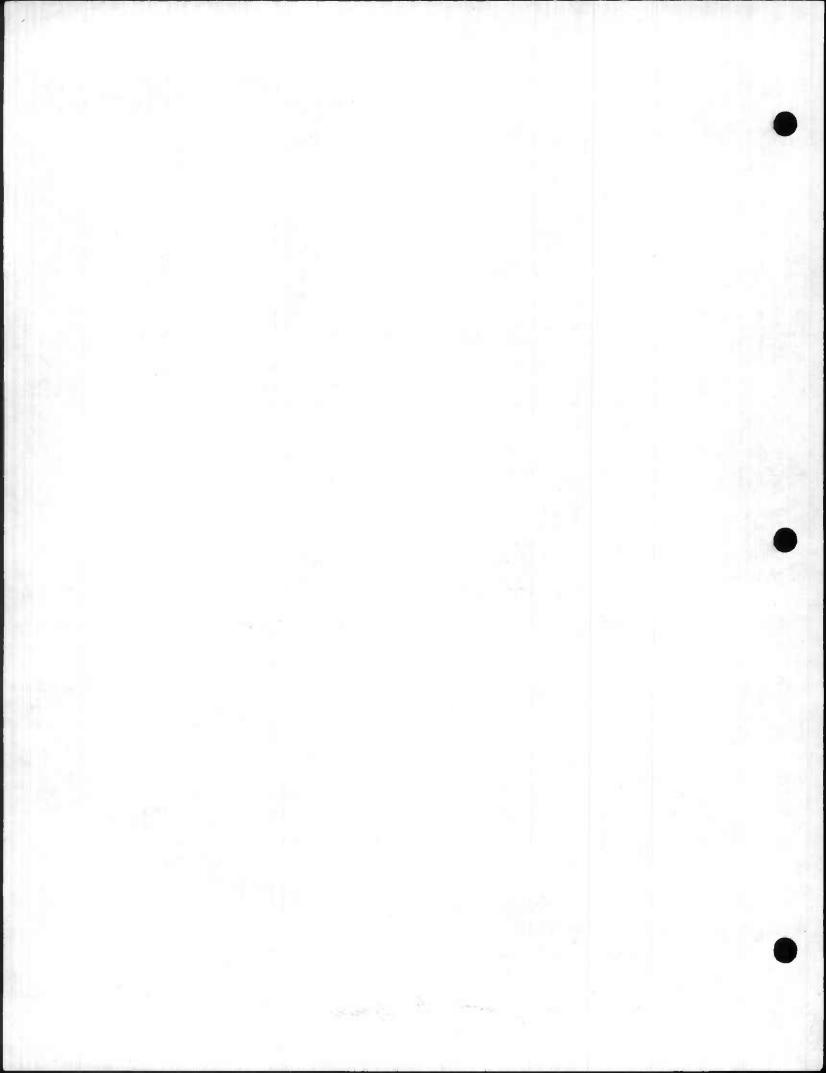
Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Ye MAY 1 7

OLIVER BACON TOWER 110 JOHNS HOPKING HOSPITAL 600 NORTH WOLFE STREET BALTIMBRE MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Bessie C. King May 08 99 5:05 am /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Prince Georges Hospital Cheverly Prince Georges If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year 6 Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys 578-12-9715 Yrs. 93 **Director** 09/09/1905 Maryland Usuel Residence of Decedent the Maryland 10c. City, Town or Location or 28a-f show 10a State 10b. County 10d. Inside City Limits 1 Nes 2 No Director Prince Georges Landover 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 0 8 with ma 23a 1908 Columbia Avenue 20785 Funeral United States Pages 1 and 2 should be filed within 72 hours after death neat of Health and Mental Hygiene.

Mit: If term 27 is marked other than "natural", or itema 23 my or other traumatic avent, are lead of Examme many or other traumatic avent, are lead of Examme man. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Detes: Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Š 3 ☑ Widowed 4 ☐ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th Private Home Maker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Oscar Barnes Mary Eliza Taylor 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rita E. Sheridan 246 Warren St. NE, Washington, Daughter DC 20002 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or pace. 5- Other (Specify) Fort Lincoln Cemetery 5/12/99 Brentwood, MD 21. Signature of Furieral Service Licenses 22. Neme end Address of Fecility Dudley Funeral Home Edward M. Dudley 3200 Rhode Island Ave., Mt. Rainier, MD 20712 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Gasico iniestinas 10 WER 12 m A) eco. na Examiner Due to (or es e consequence of): Examiner MeTaBulic Acidusis physician and s the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Acuie Rencul Fuelved 4 40 Physician/Medical Due to (or es e consequence of): d for use as t METATIAHE LAN LB Lyr e deteched f Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by signe 1 be d 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy Completed been page 2 hes 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate the Hospital or Attending Physician: funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Nes 2 No this Certification: 27, Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Deleturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29e. Certifier edical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

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State Registrar 31. Dete filed (Month, Day, Year)

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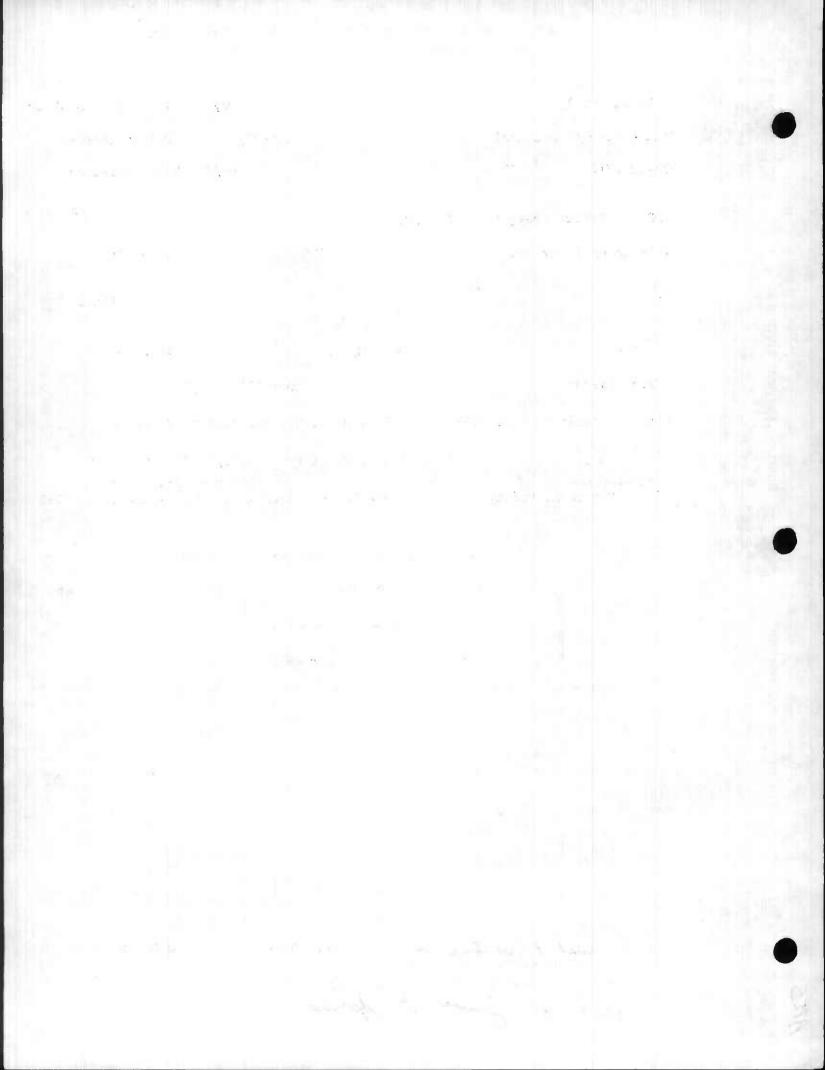
Samuel

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



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HOSPITAL DRIVE, CHEVERI



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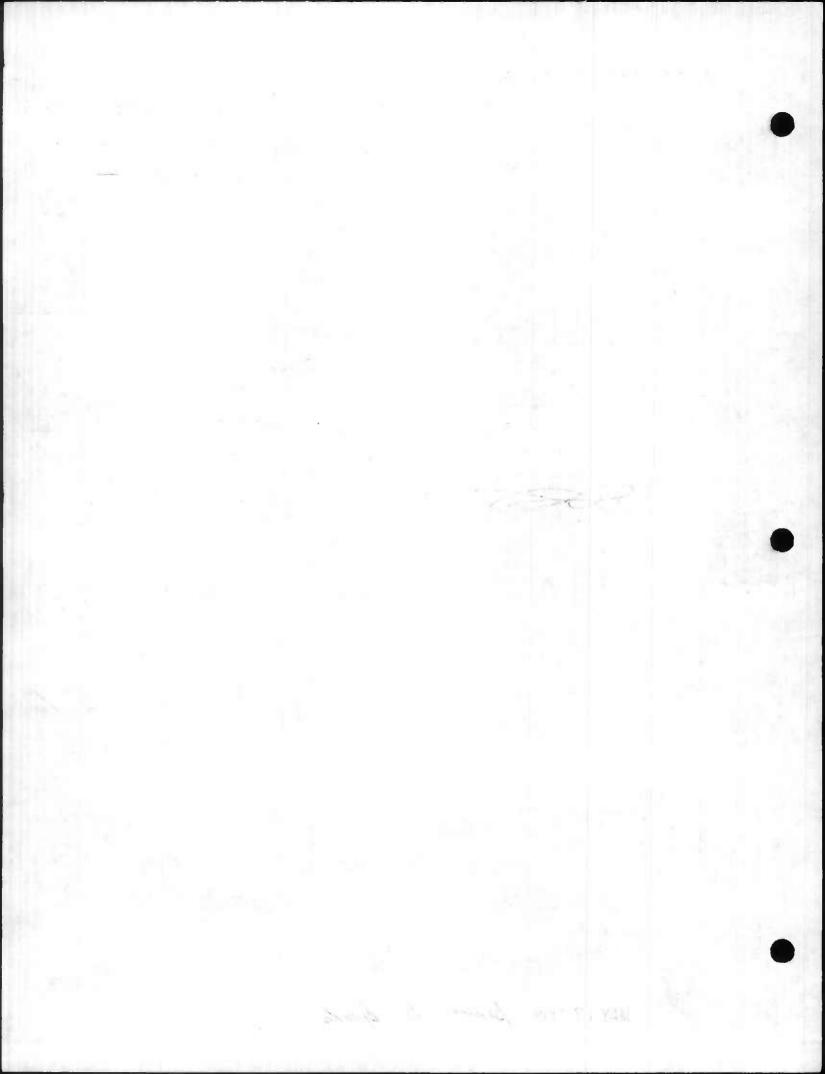
State of Maryland / Department of Health and Mental Hygiene Q 5825 Certificate of Death AMENDED #9 PER FH G771 5/17/99 AH 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death MARTORIE M. KUDRAV Month **Physician** 04.30an 99 5 13 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis
If Under 24 Hrs. 8. Det Anne-Arundel If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 PF Months Min. Hours Yrs. Director 206 07 1253 MD Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show MD Anne -Arundel Harwood 1 Yes RNO Director 28a-f must be notifi 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? natural, or Itama 23a or 4187 Old Solomons Island Road 20776 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 25kNo Specify: Specify White À ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Page Elementery/Secondary (0-12) College (1-4or 5+) Education 12 0 Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If flem 27 is merked or Michael Duffy Margaret Fleming 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Levin / Daughter 1293 Keystone Court Riva MD 21140 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion ★ Removel from State Calvary Cemetery May 17,1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not anter tha mode of dying, such as cerdiac or respiratory errest, shock, or hear teilura. List only one ceuse on each lina. Approximete Intervel Batween Onset end Death **Physician** /Medical Immediate Ceuse (Final ASCAD disaase or condition rasulting in daath) Examiner Due to (or es a consequence of): Cerebul Vasuler Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and burial-tran Due to (or es e consequance ot). Type 2 Rief der Mellela Due to (or es e consequence of): attending physician Box 68760 90 Physician/Medical the ō Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o à 1 Yes 2 No 3 Probably 4 Onknown 0 signed b Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? peed **page 2** 1□ Yes 2BNo 1 Yas 2 No certificate of Vital Physician: 25. Was case ratarred to medical Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: 28c. tnjury at Work? Division Injury 5 Pending 1 Divatural 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide edical 29a. Certifier 1/2 certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) ULD D2637 Robet M. Gree 5/13/99 30. Name and address of person who completed ceuse of daeth (Itam 23a) (Type, Print) me Oll Is/ Bungo, lie, 139 Solomonis 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

AHC

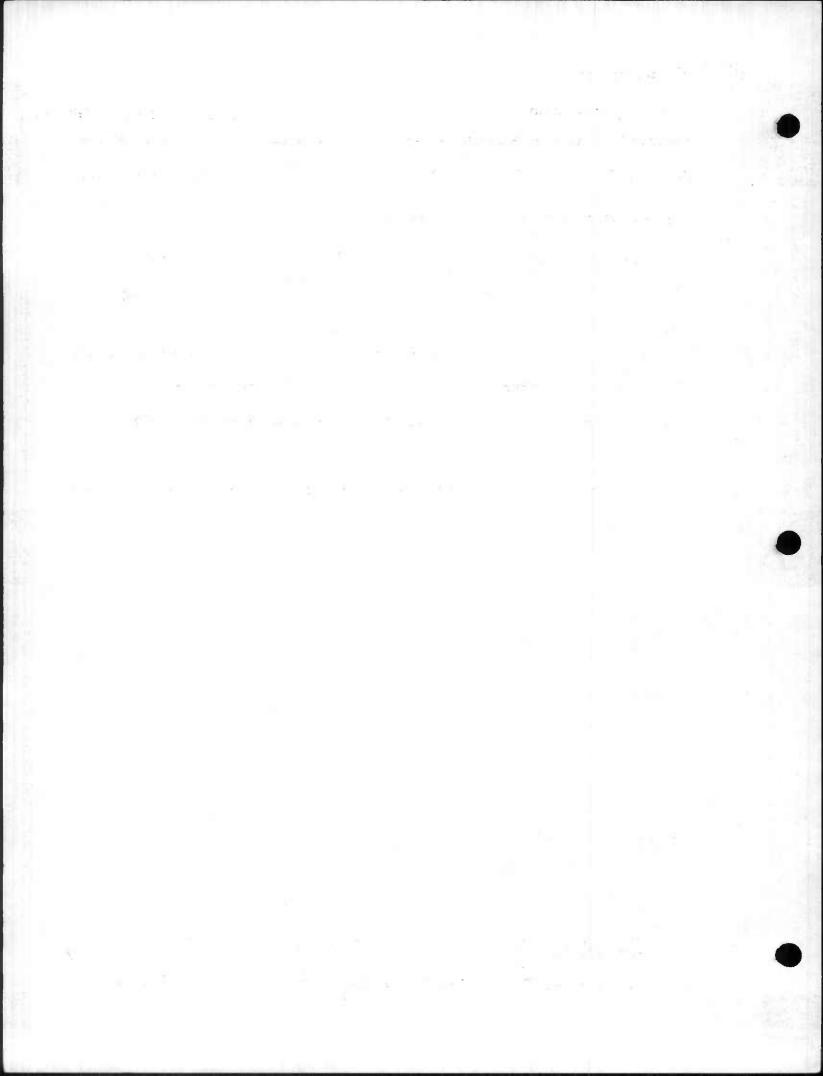
DHMH 16 Rev 6/95

Registrar

MAY 17 1999



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			1. Decedent's Neme (First, Middle, Las					-	2. Date of De Month	ath		3. Time of Death	
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	Examir		4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or							April 20 1999 r Location of Death 4c. County of Deet			
			Crofton Convales	cent & Reh	ab C	enter		Crofto	n	Anr	ne Arun	del	
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	end *		Usual Residence of Decedeni 10e. Stete 10b. County		10c. Cit	y, Town or Lo	cation				104	fnelde City Limits	
	Manyl f she	5	Maryland Anne Art	undel		nnapol:						1 ☐ Yes 2 ☒ No	
	28e	Director	10e. Street and Number				10f. Zip Code			10a Citizen of N	What Country?	,	
	M With		Hearne Road,	1604			214	0.1					
	30eth	lera	11. Marital Status	12. Was Decedent I	Ever in U	S. 13. V			? (Specify Yes or No			Indian.	
0200-91212	d 2 should be filed within 72 hours effer deeth with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28s-f show traumatic event, the Madical Examiner must be notified at	by Funeral	Never Married 2 Merrled 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 130 If Yes, Give Yeer or Detes:		l I	f Yes, specify Cubo	en, Mexican, P Specify:	uerto Rican, etc.)	Bied	Anne Arundel 9. Birthplece (Stete or Foreign Country) Maryland 10d. finside City Limit: 1		
Ş	2 ho	P	15. Decedent's Ed			16a. Deced	lent's Usuel Occup	etion		16b. Kind of B	usiness/Indust	ry	
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aitimore,	permit. Pages 1 end 2 s Depertment of Heelth or Important: if item 27 is any injury or other trau		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☒ Donetion 5 ☐ Other (Specify		20b. P	lece of Disposemetery, crem	sition (Neme of netary or other plea	ce)	Dete	20c. Location -	City or Town,	State	
Ball	Depending Depending Importations and Injury	21. Signet of Funerel Service Licensee Ronald S. Wade, Director State Anatomy Board, Baltimore, MD 21201								W. Balt:	imore S	treet	
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	hysician /Medical		fmmediete Cause (Finel	\cap		1 1						2	
	Examiner		disease or condition resulting in deeth)		me) years	
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		Be C	25. Wes case referred to medical					28. Place of	Deeth (Check only	one)			
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5 2	h. After th funeral		27. Menner of Deeth 1 Neturs 5 □ Pending	28a. Dete of Injur (Month, De)	Year)	28b. Time of Injury	28c. Injur Wor			how injury occur			
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	within 24 hours after	edicai	29e. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	yelclan: To the best of niner: On the besis of and menner sta	exeminet	wledge, deeth ion and/or inv	occurred et the tin estigation, in my o	ne, dete end p pinion, deeth o	lace, and due to the occurred et the time,	cause(s) end me date and plece,	enner as stated and due to the	d. cause(s)	
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	ļ		30. Neme and eddress of person who of	completed pause of d	eth (item	23a) (Type, F		/ -		April	00,1	177	
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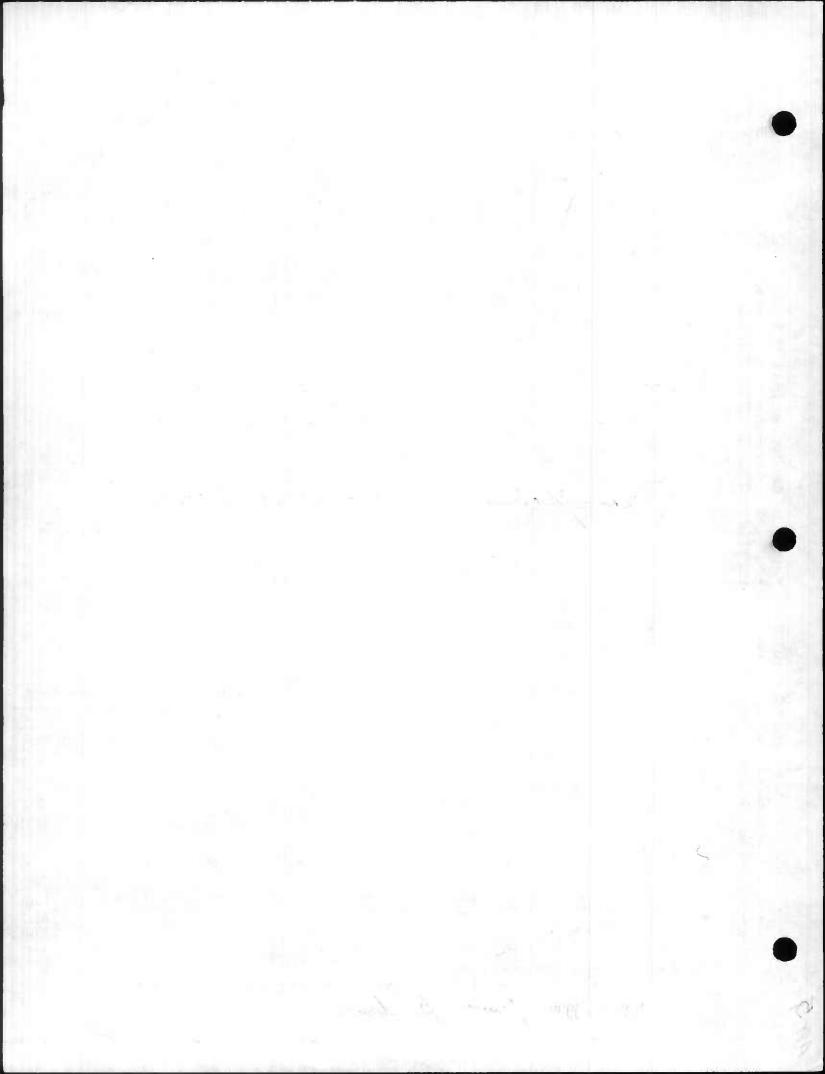
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Ohio	inian	1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath Dey	Year	3. Time of Death		
Phys /Me	dical	Nathan J. Mackey							MAY	14,		2105 PM		
Exam	niner		4a Facility Name (If not institution, give street and number) 4516 NORTHWOOD DRIVE						RE CITY	th 4c. County				
Funer Directo		5. Social Security Number 215–48–4863	5. Sex 7. Age 1 1 1	69 (In yrs. la	st birthday) Yrs.	If Under 1 Your Months De		Under 24 Hr ours Mi	8. Date of Bi (Mooth D	13-1929	9. Birthpi Count	ace (State or Foreign		
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e Maryle te-f sho diffed at	otor	Md. N/	A		ltimor							Od. Inside City Limits Yes 2 No		
ith with the Maryla 23s or 28s-f should be notified at	Funeral Director	4516 Northwood	Drive			10f. Zip Cod				10g. Citizen of 1		try?		
Harra Dat.m	by Funer	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? d 1 Yes EVAN If Yes, Give Year or Detes:	Ever in U,S. Io		Was Decedent if Yes, specify (nic Origin? (lexican, Pue pecify:	(Specify Yes or Norto Rican, etc.)	0- 14. Rec Bla Specify	R1ac	etc.		
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and 2 sho leath and 3 m 27 is ma		19a. Informant's Name/Relationshi							Pural Route Numb		Stete, Zip	Code)		
		Gwendolyn Blake	(Daughter)					. Bal	to., Md.		0h T-			
L. Pages 1 a riment of Hear fant: If Nem		20a. Method of Disposition 1				sition (Neme of metory or other Memoria	-	rk	5-21-99					
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Physician /Medica Examine	it er	23d. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. Ast only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
te be executed hysician and he buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): C. Due to (or as a consequence of):												
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eth cert	Sal	G.												
the state of	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								Yes 2 No	bacco use contribute to the cause of death?			
requir	Completed by								peri	s en autopsy ormed?	ava	are autopsy findings allable prior to appletion of cause deeth?		
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lelen: The	Be C	25. Was case referred to medical					26	Place of D	eeth (Check only		15	Yes 2□ No		
Physicien: rthis certific trai director,	0	examiner? 5/2/Yes 2 No	Hospitel:	nt 2 E	R/Outpatien	t 3□ DOA	Other		Home XX Res		er (Specifi	()		
Affecth funeral	ation: T	27. Manner of Death 19 Natural 2 Accident 5 Pending investiga	28a. Dete of Injur (Month, Day		28b. Time of Injury	28c.	Injury at Work?	2 No	1	how injury occur				
or Attending effector: Affe d in by the fund	Certification:	3 Suicide 6 Could no determin		ry - At hom . (Specify)	ne, ferm, str	eet, fectory, off	ice		28t. Location City or To	(Street and Numi own, Stete)	per or Rure	l Route Number,		
To the Hoepital or J within 24 hours efter To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only one) 1 Certifying Medical Ex	Physician: To the best of taminer: On the basis of taminer and mapping and	examinetio	edge, death on and/or inv	occurred at th	e time, d ny opinio	ate and plan n, deeth oc	ce, end due to the curred at the time	cause(s) and m	enner as st and dua to	ated. the cause(s)		
To the Fo the	×	29b. Signature and title of certifier	10/1.			29c. Lic	ense nu	mber		29d. Date signe	d (Month, i	Dey, Year)		
			4/4				OC	ME		MAY	15, 1	1999		
		30. Name and address of person wi		-0										

State Registrar

31. Date filed (Month, Day, Year) MAY 1 6 1999

32. Registrar's Signeture

Sparks



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99-2696-510

State of Maryland Department of Health and Mental Hygiene Q

2. Date of Death

Month

MAY

4b. City, Town, or Location of Death

BALTIMORE CITY

1	200	0	0	0
	J	D	2	d

Year

1999

4c. County of Death

N/A

10,_

3. Time of Death

1959 PM

XXYes 2 No

Approximate Interval Between Onset end Death

29d. Date signed (Month, Day, Year)

MAY 11, 1999

Director with the Maryland or 28a-f show the Medical Examiner must be notified at 'natural', or flems 23s filed within 72 hours after Baltimore, Maryland 21215-0020 Hygiene. permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is marked oth any Injury or other traumatic event blace. Physician /Medical

Box 68760

P.O.

Records,

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Division Attending 88

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29a, Cartifier

29b. Signatu

certificate

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Director: After the

death.

hours after

To the Hospital
within 24 hours a
To the Funeral C
completely filled

Hospital or

ITEMS: #23 PART I, II, 27, 28A-F PER MEO G771 5-24-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Denise Jauize Montague /Medical 4e Facility Name (If not institution, give street end number) **Examiner** GOOD SAMARITAN HOSPITAL **Funeral** 10a. Stete Director MH. Funeral þ Completed Be Examiner Examine certificate be executed physician s the buria

If Under 1 Year If Under 24 Hrs. Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Days Months 10M X F Maryland 34 212-86-7041 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? 21212 USA 4709 Wrenwood Ave. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes No If Yes, Give 11 Meritel Stetus 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 Yes Z Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall Hanger Home Improvement 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertina Burton Andrew Montague 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 4709 Wrenwood Ave. Balto., Md. 21212 Ethel Carey (Grandmother) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cremetion 3 □ Removel from Stete 5/17/99 Dundalk Maryland Sacred Heart Of Jesus 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funerel Service Dicensee Caple Funeral Service 23a. Past Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Light only one cause on each line. 5502 Winner Ave. Balto., Md. 21215 tramedlete Cause (Finat disease or condition resulting in deeth) NARCOTIC INTOXICATION Due to (or es a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or trijury thal initiated events resulting th death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ACQUIRED IMMUNODEFICIENCY SYNDROME þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX Yes 2 No 1 Inpatient 2 ER/Outpatient DOA 28c. Injury at Work? 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural 1 Yes 2 No 5-10-99 UNKNOWN 2 Accident UNKNOWN 6) Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4709 WRENWOOD AVE, 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BALTIMORE, MARYLAND

State Registrar 31. Dete liled (Month, Dey, Year) 1999 **MAY 15**

Locke

d title of certifier

111 Penn Street, Baltimore, Maryland 21201 32 Registrer's Signature

who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

OCME

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ 15829

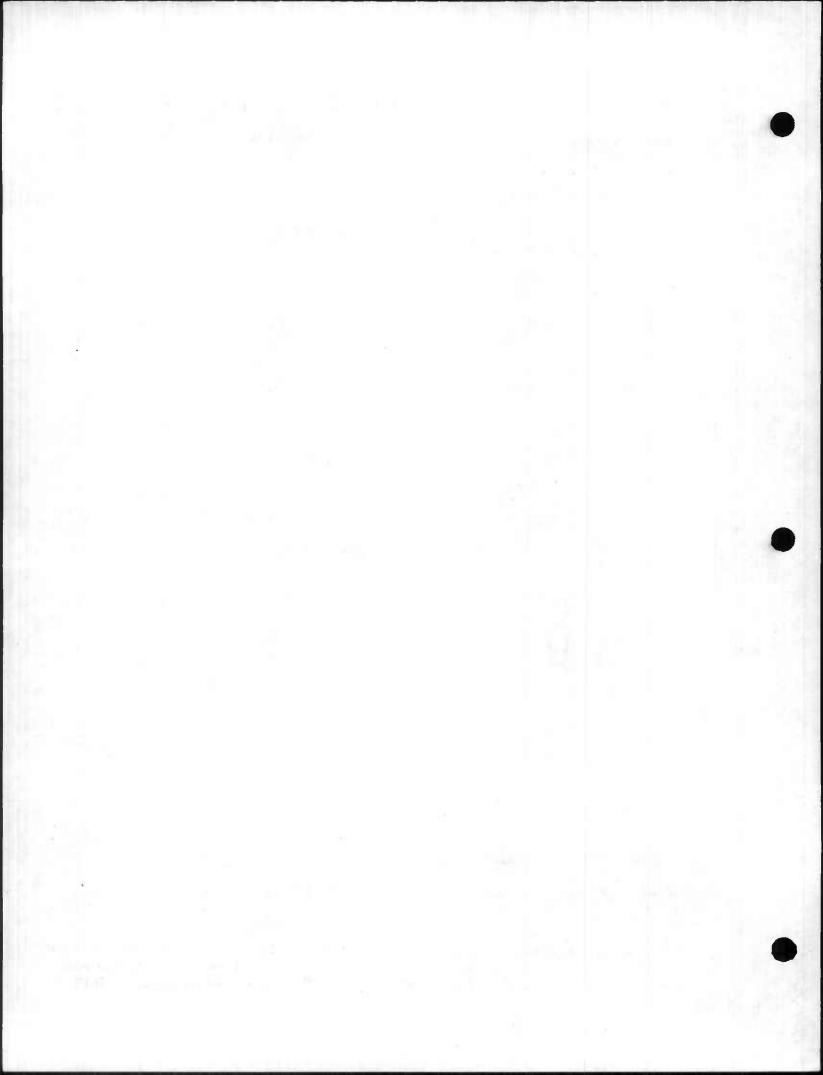
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Examiner	4a Facility Nema (If I	not institution, giva	street and num	ber)				4b. City, Town, or		h 4c. County			
	JOHNS HO	PKINZ	ItOSP	ITOL				BACTIL	LORE	NA	1		
Funeral Director	5. Social Security Nur 237-72-		X 20 F	. Aga (In yrs.	last birthday) Yrs.	If Undar Months	1 Yaar Days	If Under 24 Hrs Hours Min				lace (Stata or Foreign try)	
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or 28s-f s be notified Director			_	B	altimo							XX Yas 2 No	
Dir.	10e. Street and Numb					10f. Zip				10g. Citizen of 1	What Cour	itry?	
ount oral	1106 Ha	riora A					202			USA			
at, or learns 23a or 28a-f shor Examiner must be notified at by Furneral Director	11. Marital Status 1 Nevar Married 3 Widowed 4		12. Was Deced Armed Ford Yas 2 If Yes, Giva Yaar or Dat	ces? 2 No		Wes Deced f Yas, spec i ☐ Yas		dispenic Origin? (an, Mexican, Pua Specify:	Specify Yes or No to Rican, etc.)	Specify	ce - Amaric ck, Whita, y: Bla	atc.	
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at to	12th gr	ade	NA		Maj	or				MD. Co	Correctional		
9 5 9	17. Fathar's Nama (F	irst, Middle, Last)						18. Mother's Na	me (First, Middle	Meidan Sumama)			
To E	Johnnie		Moore					Addie	R	eckum			
-	19a. Informent's Nen	ne/Ralationship (T)	rpe, Print)		19b. Mailir	ng Addrass	(Street	and Number or F			Stata, Zip	Code)	
the tra	Delores	J. Moo	re		4890	Gro	use	Run Dr	ive St	ockton	. CA	95207	
当ち	1X Burial 2	Delores J. Moore 4890 Grouse Run Drive Stockton, C 20a. Method of Disposition 1XD Burial 2 Cramation 3 Removel from Steta 4 Donation 5 Othar (Specify) 4890 Grouse Run Drive Stockton, C 20b. Place of Disposition (Name of cematary, cramatory or othar place) Garrison Forest VA Cem. 05-18-99 Ow										wn, Stata MD	
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	23a. Pale?. Entar the	disaasa, or compl failura. List only o	ications that ca	used the daa							aven	Approximata	
lal-transit Lxaminer	Immediata Cause (Fi diseasa or condition rasulting In death)	nal	P		or as a consec	•	mi	30USIM				24 Itour	
edical	Sequentially list conditions, if any, leeding to immadiate cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of):												
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signed by the attend d be detached for us d by Physician/									the cause of death' bably 4 Unknow				
2 shoul									24a. Was	an eutopsy ormed?	ev	ara autopsy findings ellable prior to mplation of cause death?	
page Com	100								10	Yas 2 No	10	Yas 20 No	
rector, par rector, par Be Co	25. Was case refarre	d to medical				11111		26. Placa of De	ath (Check only	ona)	1		
To F	exeminar?	0	lospital:	patiant 2	ER/Outpatier	t 3 DC	OA Ott	ner: 4 Nursing	Homa 5 ☐ Rasi	Idanca 6 Oth	nar (Specif	y)	
	27. Mannar of Death 1 Neturel 2 Accidant	5 Pending Investigation	28a. Deta of (Month)	Injury Day Year)	28b. Tima of Injury		8c. Inju		1	how injury occur			
al Director: After tied in by the funeral	3 Suicida 4 Homicide	6 Could not be detarmined		f Injury - At h	oma, farm, str	eet, factory	, office		28f. Location (City or To	Street and Numb wn, Stata)	ber or Rura	l Routa Number,	
in the	29e. Cartifiar 1 (Check only 2	Certifying Phys	sician: To the b ner: On tha bas and manne	Is of axamine	owledga, daath ation end/or inv	occurred a rastigation,	at tha tii	me, data and plac ppinion, death occ	e, and dua to tha urred at the tima,	cause(s) and me date end plece,	enner as s and due to	tated. tha cause(s)	
To the Fu	29b. Signetura end tit	la of certifier	1	In				a number		29d. Data signe	_	1 10-0	
	30. Nama and addras	s of person who co	mplated causa	of death (Ite	n 23a) (Type			13		28. 41			

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year) 32. Registrar's Signatura

OLIVER BACON TOWER 110 JOHNS HOPKING HOSPITAZ GOO NORTH WOLFE STREET



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		State	of Maryland / Department of Health and Mer	ntal Hygiene 9 9
Amended#24a	perPhyG771	5/17/99 EW	Certificate of Death	Reg. No.
		4.4 4	1-	

3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev Year **Physician** MCCOURT CHARLES 1999 APRIL 22 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BACTIMURE SAMARITAN HUSPITAL If Under 1 Year
Months Deys If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Day, Year) 6. Sex Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 217143265 Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show eny injury or other traumatic event, fine Mod cal Examiner must be notified an once. 10a State 10b County 10c. City, Town or Location 10d. inside City Limits Balto 1 Ves 2 □ No mo Director Maryland 10e. Street end Number 10g. Citizen of What Country? Plymuth Ra 6210 US citizen Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: WWT 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Never Married 2 Married 1 Yes 2 No Specify: specify: Whote Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) 0 Travel Agency Travel Agent 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Charles McCourt Sr. Emma Walters 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Kathryn McCourt/wife 6210 Plymouth Avenue, Baltimore, MD 21214 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremetion 3 □ Removal from Stete 4 Bonaton Dother (Specify) State A natony Board 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Prector Konald S. Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Baltimore, Maryland 21201

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Baltimore, Maryland 21201 Approximete Intarvel Batwaan Onset and Deeth Physician /Medical Immediate Cause (Finel a. Metabolic Acidosis

Due to (or es e consequence of): 1 day disease or condition resulting in deeth) Examiner Examiner Acute Renal ettending physicien end for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated evants resulting in deeth) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): signed by the e Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis by 24b. Wara eutopsy findings eveileble prior to completion of cause of daath? 24e. Wes en eutopsy performed? Be Completed s certificete hea director, page 2 1 ☐ Yes 2 No 1 □ Yas 2 □ No director, or Attending Physician: 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☑ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 28e. Date of injury (Month, Dey Year) 27. Menner of Deeth 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Neturei 5 Pending n 24 hours efter death.

Ne Funeral Director: Af pletely filled in by the fu 1 Yes 2 No death. Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicida To the Hospital of within 24 hours of To the Funeral Discompletely filled is 29a. Certifier (Check only one) 1to Certifying Physician: To the bast of my knowledge, daath occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number APRIL 22, 1999 kean mo P-11403 5601 LOCA RAVEN HOSPITAL 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

CTOOP SAMARITAN HOSPITAL

32. Registur's Signatura

BAITIMORE MD 21239

DHMH 16 Rev 6/95

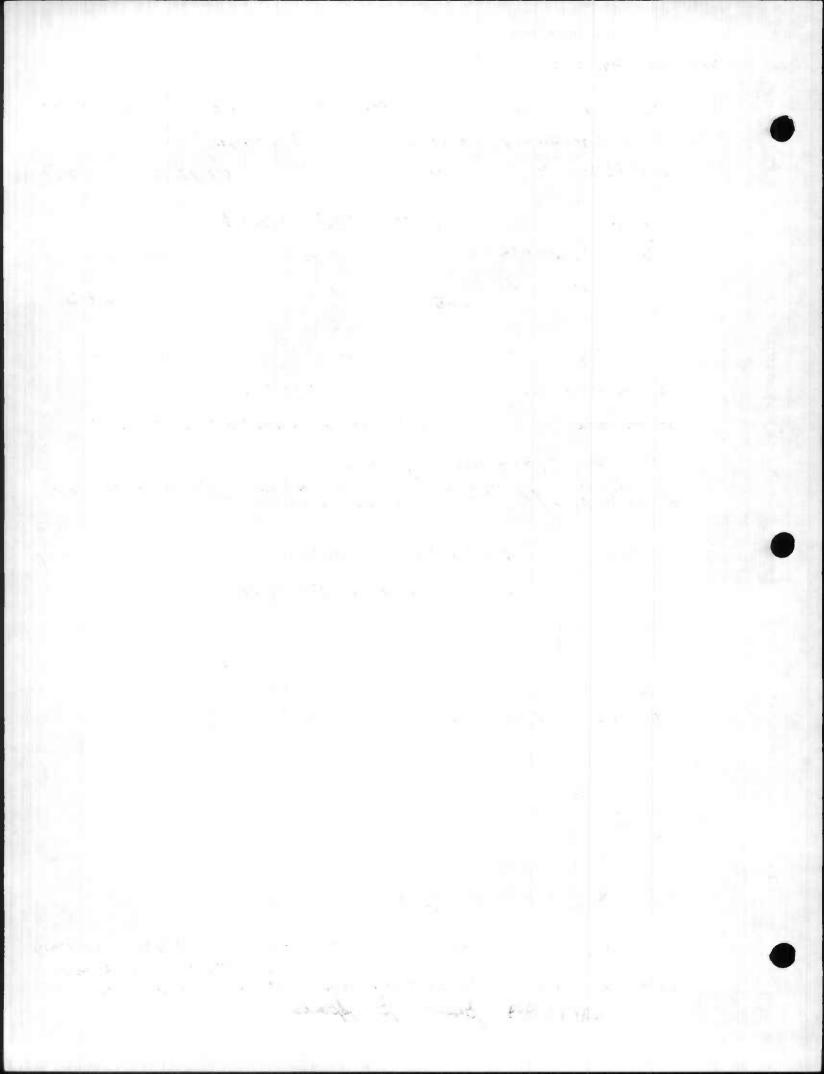
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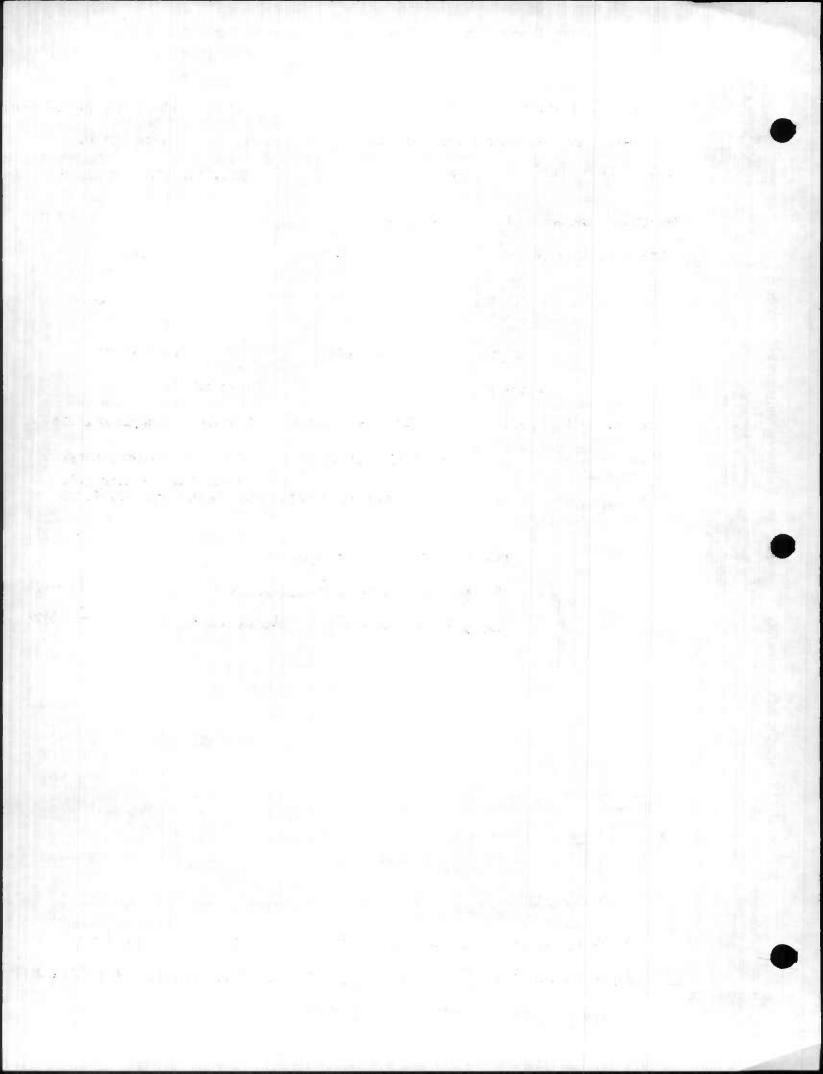
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31. Data filad (Month, Day, Yaar)

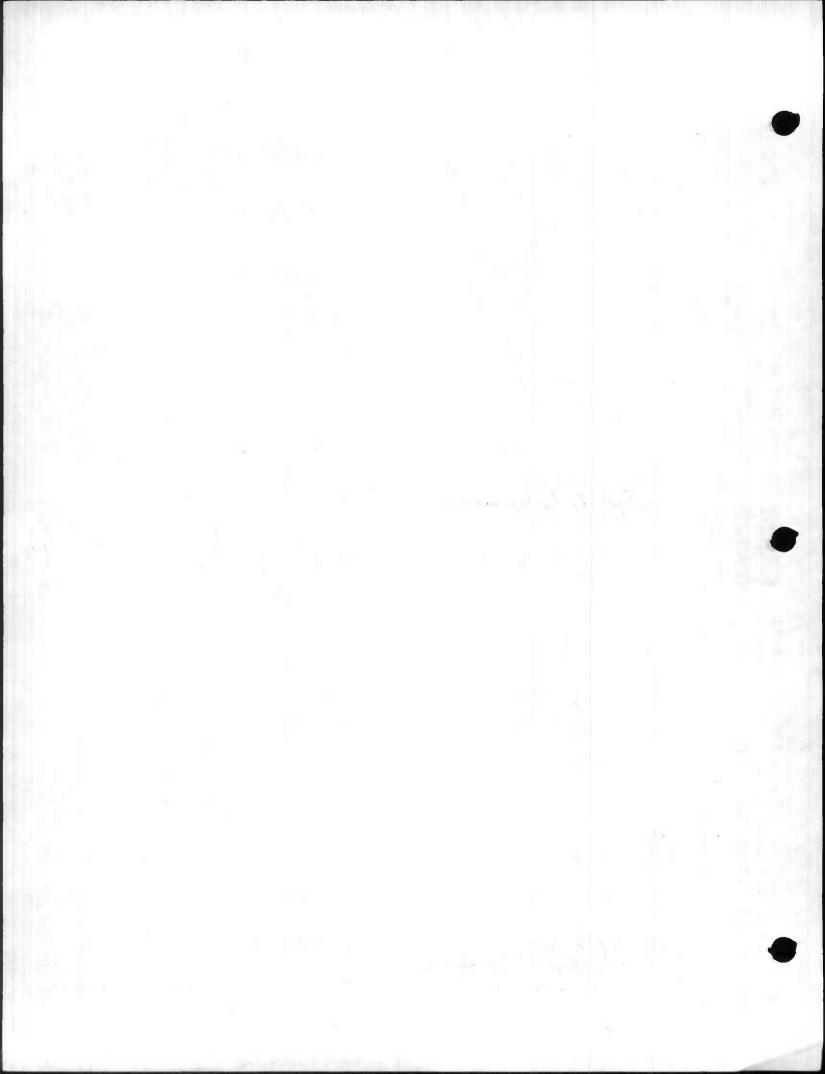


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Physician /Medical	WILLIA	m	AUL			02	12	99	10.50 A		
Examiner	4a Facility Nema (If not institution, gir	re street and number)			4b. City, Town, or						
(P)	Genesis Elderc			Lane If Under 1 Year	Baltimor			Aru			
Funeral Director		ARTHUR OF THE	yrs. last birthday) 2 Yrs.	Months Days					laca (Stata or Foraign try) tland		
and wa	10a. Stata 10b. County	100	. City, Town or Lo	cation				1	0d. Insida City Limits		
with the Maryland a or 28a-1 show the notified at	Maryland Anne Ar	undel	Baltimor	re					1 ☐ Yes 2 ☑ No		
or 28	10e. Street and Number			10f. Zip Coda		10g. Citizan of What Country?					
death w	5308 - 4th Stre			212		U.S.					
or he or he		12. Was Decedant Evar Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Detes:		13. Wes Decedant of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 □ Yas 2 □ X No Specify:					an Indien, etc. nite		
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Aar 2 sho is mud is mu	19a. Informant's Name/Ralationship				t and Number or Ri						
iore, N ges 1 and t of Health if item 27 or other tr	Agnes F. Paul 20a. Mathod of Disposition	/ Wife	5308 Ob. Place of Dispo	- 4th S	treet	Baltimo	re, Mary				
Baltimore bemit. Pages 1: bepartment of He mportant: if the my injury or oth	1 XBurial 2 Crametion 3 L	Removal from Stata	camatary, cran	ramatory or other placa) ill Cemetery 5/14/99 Baltimor							
Baltim permit. Pag Department Important: I any Injury o once.	21. Signeture of Funeral Service Licansea 22. Nama and Address of Fecility Gonce Funeral Home P.A 4001 Ritchie Highway Baltimore, Md. 2122										
Physician /Medical Examiner	23a. Part1. Enter the disaasa, or con shock, or haart failura. List only Immediate Cause (Final disaasa or condition	plications that caused the ona causa on each line.	daeth. Do not and	ar the moda of dy	ing, such es cardia	c or respiratory a	rrast,	1 1 1	Approximate Interval Batween Onsat and Daath		
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68760, flicate be executed physician and as the bunial-transit editical Examiner		c. Cere	to (or as a consecto (or as a consecto)	scula	n dir	nas	و	1	20yn		
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of Vital Records, P Physician: The law requires that this certificate has been signed tral director, page 2 should be det.: To Be Completed by P							. Was an autopsy performed? 24b. Were autopsy find available prior to complation of death?				
The law ate has page 2						10	Yas 2 No	10	☐ Yas 2☐ No		
f Vital F ysician: The ysician: The director, pag	25. Was case ratarred to medical				26. Placa of De	ath (Check only	one)	1			
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Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Cartifiar 1X Certifying Pl (Check only one) Madical Exa	nystcian: To the best of my miner: On the basis of axa and manner stated.	knowledga, daatl mination and/or In	n occurrad at the t vastigation, in my	time, date and place opinion, daath occu	a, and due to the urred at tha tima,	cause(s) and middle data and place,	enner as s and due to	tated. the cause(s)		
To the within To the comp			_ MU	_	nsa number	+3	29d. Data signe	d (Month,	Day, Year)		
	30. Nama and addrass of person who	LAA TAA	(Item 23a) (Type,	Print)	LANE,	BALT	mone	MI),21225		
State	31. Date filed (Month, Day, Year)	32. Registrar's S			ks				1		
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miner	4a Facility Name (If not institution, g	rive street and number)			4	lb. City, Town, or	Location of Death	4c. County	of Death									
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eral ctor	5. Social Security Number 216 10 3393 Usuel Residence of Decedent	Sex 7. Age	9 (In yrs. last birt	Month	ler 1 Yeer s Days	Hours Min		0, 1911	9. Birthplace Country) Mary]	(State or Foreign								
rector	10a. State 10b. County	/a	10c. City, Town	or Location	В	altimore				nside City Limits XYes 2 □ No								
Funeral Director	10e. Street and Number 4222 Woodlea Av	e.		10f. 2	Zip Code	21206		10g. Citizen of V Unite	What Country?	es								
þ	11. Marital Status 1 Never Married 2 Memoc 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 12 Yes 2 New Year or Dates:				ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Rec Blee Specify	e - American Inck, White, etc.	dian, nite								
To Be Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5	41	Decedent's Us (Give kind of I life. DO NOT TUCK D:		ation during most of wo f)	orking		usiness/Industry	150								
e s	17. Father's Name (First, Middle, Last) Rudolph Otto Quandt Clara Estelle									jle								
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2	Dolores J. Quand	t / Wife							21206									
ury or other t	20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Local Company of the place of Disposition (Neme of cemetery, cremetory or other place)								altimore, MD									
eny Inj	21. Signature of Funeral Service Lic	ensee)		CAFA	Step		ohrmann		ore. MT	21286								
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Medical Certificat	4 ☐ Homicide determine	building, etc					City or Tow	m, Stete)										
completely filled in Medical Cerr	(Check only 2 Medical Exp	Physician: To the best of aminer: On the basis of and manner sta	examination and	Vor investigati	on, in my o	pinion, death occ	urred et the time, o	date and place,	and due to the	ceuse(s)								
woo ≥	29b. Signature and title of extifier			2	9c. Licens	e number	1	29d. Date signe										
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 3:15 A.M 2 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, giva street and number) 4c. County of Death Baltmore owson enter 11chnsT If Under 24 Hrs. 8. Data of Birth Hours Min. 8. Data of Birth (Month, Day, Yaar) if Undar 1 Yaer 5. Social Sacurity Number 9. Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 1 M 2 F Months Days 212-26-0257 Usual Rasidence of Decedant Yrs. Ma 6 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore parks 1 Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Lower Glencoe 21152 ,5.4 .0 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yas 2 No If Yas, Giva Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - American Indian Black, Whita, atc. 1 Nevar Married 2 Married 1□ Yas 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast greda complated) 16b. Kind of Businass/Industry Battimore County Elementary/Secondary (0-12) Collaga (1-4or 5+) abover Department grade WA 17 Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Kinggold es mella 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Glencoe Road Sparks, Md - NIECE ower HICE 1005 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata 5-15-99 evenson enetery 4 Donation 5 Othar (Specify) natural of Funaral Service Licenses Name and Addrass of Facility Balto, nd 21215 Hint. Enter the diseesa, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List on Jone cause on each line. wabash Arenne Approximata Intarval Batween Onsat and Death Immediate Ceuse (Final diseasa or condition rasulting In daath) ears Dua to (or as a consequence of) Sequentielly list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting In daath) Lest Dua to (or as e consequence of) Dua to (or as a consequanca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of ceusa of death? 24a. Was en autopsy performed? 2 X No 1 Yes 1 ☐ Yas 2 No 25. Was casa referred to medice! axaminer? 26. Placa of Death (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accidant 1 ☐ Yas 2 ☐ No 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Steta) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

P.O. Records, Division of Vital

attending physician and for use as the bunal-transit certificate be axecuted as the yd bengis peed certificate has Physician: this funeral After t or Attending death. within 24 hours after death To the Funeral Director: A completely filled in by tha f

Physician

/Medical

Examiner

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event, the Medical Examiner must be

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Department of Health a Important: if them 27 is any injury or other trea ance.

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29b. Signature and title of certifian

29a. Cartifier (Check only one)

Pages 1

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State Registrar

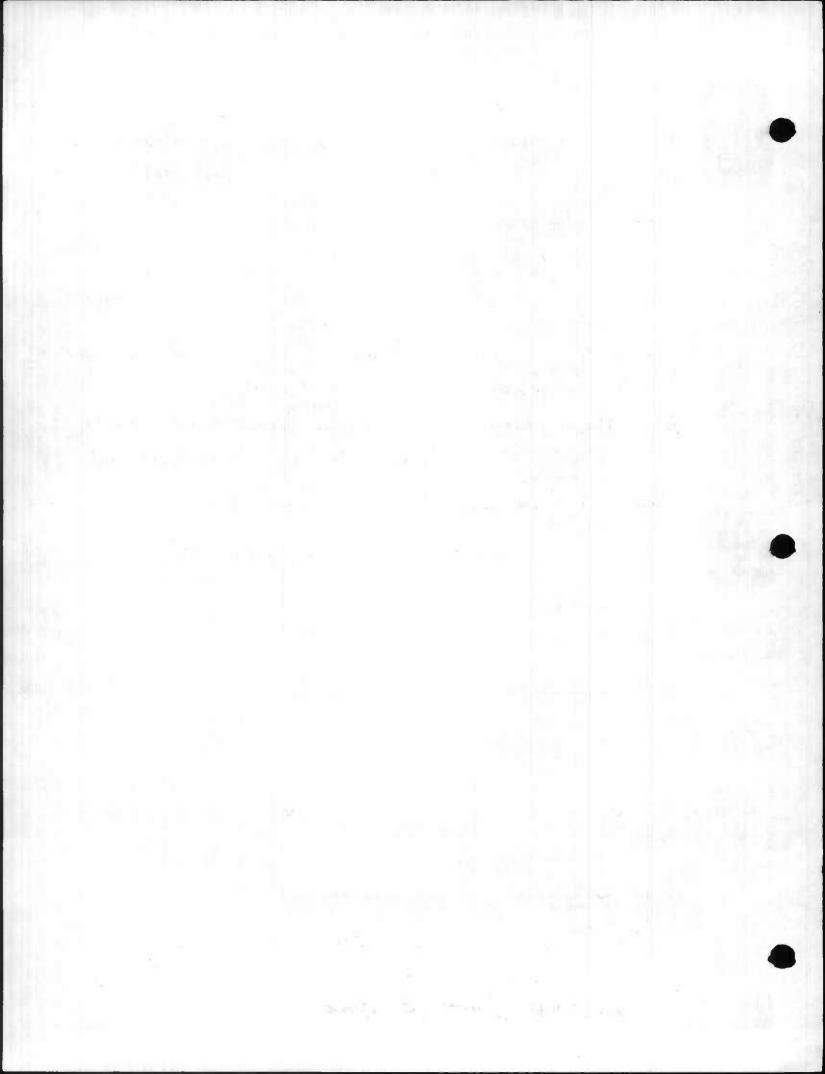
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29c. License number

1 Certifying Phyeician: To the best of my knowladga, daath occurred et tha tima, data and place, and dua to tha ceusa(s) and mannar as stated.
2 Medical Examinar: On the bests of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, end dua to tha cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

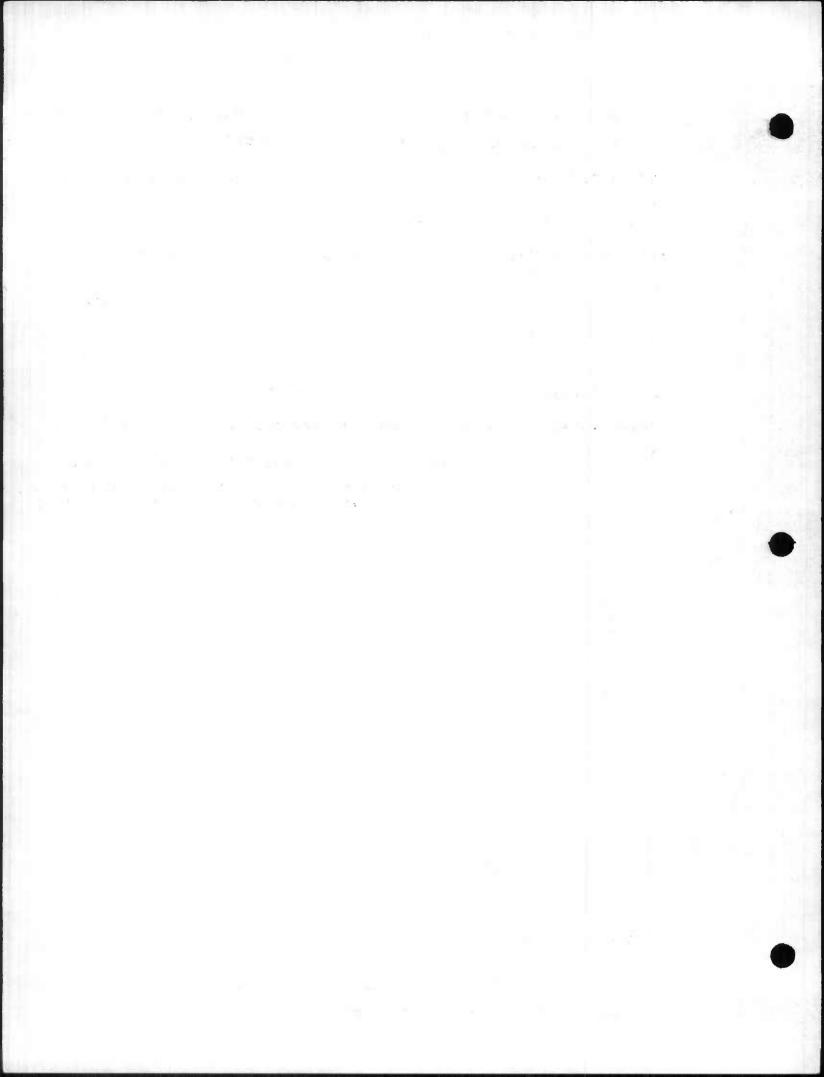
nplated cause of death (Itam 23a) (Type, Print) onles St. Balto. Md21204

32. Registrar's Signetura



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			State of Ma	aryland /	Certifica			ivieritat i iy	Reg. No.	15	834		
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of should be filed within 72 hours after death with the Maryland of and Mental Hygiene. 7 is marked other than "netural", or frems 28a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status **ENevar Married 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N			edant of Hecify Cubi	ispanic Origin? (S an, Maxican, Puan Specify:	pecify Yas or No to Rican, atc.)	pecify Yas or No- Prican, atc.) 14. Race - Amarican Indian, Biack, White, atc. Specify: White				
"natural"	Be Completed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E (Specify only highest gr	Year or Datas: ducation ade completed)	16	a. Decedant's Us (Giva kind of w	ual Occup	etion during most of wo	16b. Kind of Bu					
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Menid	2	James Ratajo	zak						zepkows				
and and and and and and and and and and		19a. Informant's Name/Relationship	Type, Print)	19	b. Meiling Addre	ss (Street	and Number or Ru	ural Route Numb	er, City or Town,	Stata, Zip Co	de)		
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Department Important: It any injury o		21. Signatura of Fungeral Service Licensee Bradley-Ashton-Matthews Funeral Home, In 2134 Willow Spring Rd., Balto., Md. 21222											
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/Medical Examiner		Immediata Causa (Final disease or condition rasulting in daath)	a	spira	d,m		eum on.	a			IWK		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedant'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year 99 **Physician** 350 47 Saverwald HOWARD 8 2 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore
If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year) Mospita Jecours If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Mary lance 218-62-1602 Yrs. Director 10,25 Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. inelde City Limits marked other than "natural", or items 23a or 28a-f show imatic event, the Modical Examinat must be notified at Battimore 1 Yes 200 No Catonsvill Directo 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? With Midge 21128 mondson Noad Funeral Pages 1 end 2 should be filed within 72 hours efter death nent of Health end Mental Hyglene. If item 27 is marked other than "natural", or items 23 int: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementery/Secondary (0-12) College (1-4or 5+) Trucking 12 18. Mother's Name (First, Middla, Maiden Sumawa) 17. Fether's Name (First, Middle, Last) Be Sayerwale Virginia Tracey 19b. Mailing Address (Street and Number or Rural Route Number, Chy 5002 Edmandson Baltimore 19a. Informant's Name/Retetionship (Type, Print) Town, State, Zip Code) Baltimore 21229 Nancy Stanton other Department of Heal Important: If item 2 any Injury or other 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) tropolitan Cremotory 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Funeral Options, 6416 Frederick 21228 Rel Catonsu, 23e. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner physicien end s the buriel-transit that the death cartificate be executed Sequentietly list conditions, if eny, laading to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): 8 990 P.O. Box 68760 Physician/Medicai Due to (or es e consequence of): 89 esn 10 23b. Did tobacco use contribute to the cause of death? Pert It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ The law requires 24b. Wara autopsy findings eveilable prior to completion of ceuse of death? Completed 24e. Was an autopsy performed' this certificate he ral director, page 20 No 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 8 25. Was cese referred to medical examiner? 26. Pleca of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 20 No Certification: To 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After 5 Panding Investigation Natural death. 1 🗆 Yes 2 Accident ofter death Director: A d in by the f 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours eft To the Funeral Di completely filled in Certifying Physician: To tha bast of my knowledga, deeth occurred et the time, dete end plece, end dua to tha causa(s) and mennar es steted.

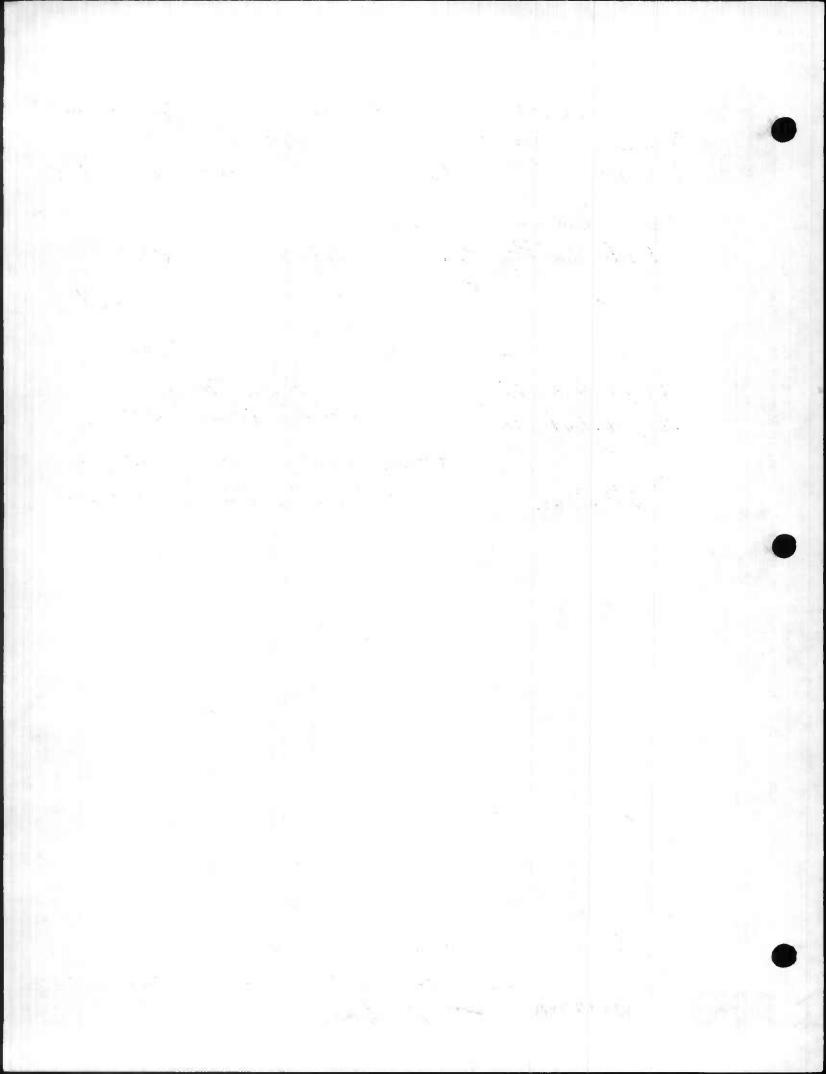
2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, daeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end titla of certifiar 29c. Licensa number cause of deeth (Itam 23a) (Type, Print)

2000 W.

32. Registrer's Signeture

State Registrar 31. Dete fited (Month, Day, Yaar) MAY 17

1999



State of Maryland / Department of Health and Mental Hygiene Amended#23apt1 perPHYG771 5/17/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Dev **Physician** Month Year Walter Smith April 30, 1999 7:30 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmead Cockeysville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 93 547-26-3455 Yrs. Director April 29, 1905 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yas 2 No Director Cockeysville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours effer death with 1 Department of Health and Mental Hygiene.
Important: If I fem 27 is marked other than "natural", or items 23a or 2 any lijury or other traumatic event, the Mental Page 1 and 10 or 10 once. 13801 York Road 21030 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 US Goverment Employee Goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Walter H. Smith Alice C. Grimes 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Mr. R. Taylor McLean/ Attoney 102 W. Pennsylvania Ave Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May IO, 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1999 Bladensburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final RENAL FAILURE disease or condition resulting in death) Examiner Examiner HYPERTENSION The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last end Due to (or as a consequence of): LEFT RENAL MASS Division of Vital Records, P.O. Box 68760, ettending physician for use es the burie Physician/Medical Due to (or as a consequence of): signed by the eld be deteched for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown IGESTIVE HEART FAILURE by 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 2 1 No 2 No After this certificate or Attending Physician: Be director 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Matural 5 Pending Investigation 1 Yes death. 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) efter 4 Homicide within 24 hours eff To the Funerel Di completely filled in To the Hospitai 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) RD., COCKEYSVILLE 31. Date filed (Month, Day). 32. Registrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #24a PER M.D. G772 6/4/99 AH 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Day Month **Physician** KONALD J. AVERILL 440 Am MAY 1999 16 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PITAL BALTIMONE VETERANS HOSPITAL ADMINISTRATION MARYLAND BALTIMORE n/a 8. Date of Birth (Month, Day, Yaar) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** 10 M 2 F Days Months Hours 69 231-32-6350 Ohio Director OCTOSGR 27, 1929 Usual Rasidanca of Decedant the Maryland 10a Stata 10h County 10c. City, Town or Location 10d, Insida City Limits "naturel", or items 23a or 28a-f ahow 1 X Yes 2 □ No Director Maryland n/a **Baltimore** 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 72 hours after death with 2000 Odell Ave. #512 21237 United States Funeral 12. Was Decedant Ever in U,S. Agreed Forces? 20 AVas 2 □ No If Yes, Give Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2X No Specify: Baltimore, Maryland 21215-0020 White þ 3 Widowed 4 NDivorced nd 2 should be filed within 72 hou sith and Mental Hygiena. 27 is marked other than "naturel r treumatic avent, ina Moucal E. Completed 15. Dacedant's Education (Specify only highest grada complated) 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Collega (1-4or 5+) Elamantary/Secondary (0-12) Welder / Boiler Maker Dry Dock Comp. 6 18. Mothar's Neme (First, Middle, Malden Sumema) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be filt mant of Haalth and Mental Hy ant: If them 27 is marked oth lury or other treumstic avent Be Averi11 (Unknown) Elsie Mae (Unknown) 19a. Informant's Name/Ralationship (Type, Print) 19b. Melling Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Ronda Averill Vistante/Daughter 506 N. Stricker St., Baltimore, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cremetory or other placa) 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata Department of important: If I any Injury or DACS. Maryland Veterans Cem. 5/21/99 Crownsville, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility CAFA Stephen D. Lohrmann P.A. lux 8717 Green Pastures Dr., Baltimore, MD 8717 Green Pastures Dr., Ba
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 21286 Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) NEUMONIA 10 DAYS Examiner Dua to (or as a consaquanca of): Examiner (RESOLVED PEWS DAYS PRIOR TO DEATH) 5 DAYS NEUROPENIA physician and s tha bunal-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiata cause. Entar Undarlying Causa (Disaase or Injury that initieted events rasulting in daath) Last Dua to (or as a consequence of): SMALL CELL CHEMOTHERAPY FOR LUNG CANCER Box 68760 SIDE EFFECTS OF LYGAR Physician/Medical Due to (or as a consequence of): attanding p signed by the a Pert tl. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 ■Yes 2 No 3 Probably 4 Unknown SMALL CELL LUNG CANCER Division of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? should 24a. Was an autopsy Completed il director, paga 2 s 1 Yes THE 1 ☐ Yas 2 ☐ No Attanding Physician: Be 25. Was casa rafarrad to medical examinar? 28. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) ဥ 1 Yas 2 No 1 Impatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funaral 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? Aftar 1 Natural 5 Panding death. 1 Yas 2 No Invastigation 2 Accidant after death Director: / d in by the f 6 Could not be datarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dir complataly filled in 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steled.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steled. Medical 29a. Cartifier (Check only one)

State Registrar

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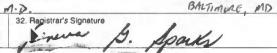
ABRAHAM

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

29b. Signatura and titla of certifier

TITUS

31. Data filad (Month, Day, Year)



29c. Licansa number

P12359

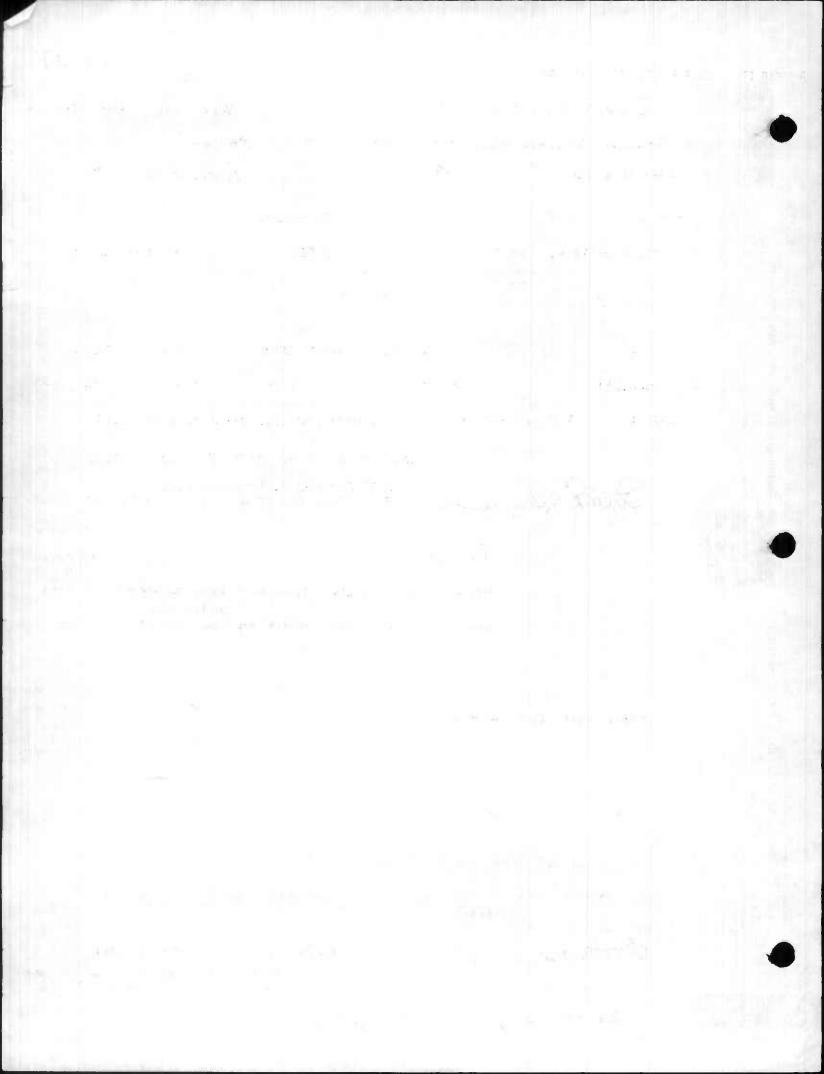
29d. Data signed (Month, Day, Year)

HOSPITAL)

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MAY 16 1999

11 SOUTH GREEN STREET (UNIVERSITY OF



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene' Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year der OWAT 1999 30 0930 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Inunde1 Hospital Burnie ColeN If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, 07 17 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours M 2 □ F ANNE ARUNDEL 57 Director 220-38-5815 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or frams 23s or 28s-f shor traumatic event, the Medical Examination must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with Funeral 109 Janelin Drive death 21061 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 1 DAYes 2 □ No if Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 end 2 should be filed within 72 hours after onent of Health end Mentai Hyglane. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Merried SpecifyWHITE altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION REMODELING 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HUBERT ALDER ANNABELLE LILLIAN GOVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Depertment of Health Important: If Item 27 WILMER ALDER-BROTHER 833 CLARK STATION RD. SEVERN, MD. 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 Burial Cremation 3 Removal from State METRO CREMATORY 5/4/99 BALTIMORE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility STALLINGS FUNERAL HOME 3111 MOUNTAIN ROAD PASADENA, MD. 21122
PASADENA, MD. 21122
PASADENA, MD. 21122
PASADENA, MD. 21122 Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bud Due to (or as a consequence of) The lew requires that the death certificate be execu -burielphysician the buriel Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): attanding p signed by the at Id be detached for Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown by 24b. Were autopsy findings evallable prior to Completed 24e. Was an autopsy performed? peen completion of ceuse of death? this certificata hes 25 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 28d. Describe how injury occurred Affer 1 Naturel 5 Pending investigation To the Mospital or Attendin within 24 hours after death. To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Deputy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 695 America JONES

MO

32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

MAY 18



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Snowden Osborne Alfred 1999 May 13 9:15 a.m. /Medical 4a Facility Name (If not institution, giva straat end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Madonna Heritage Jarrettsville Harford Hours Min. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Yrs 219-42-6107 90 Kentucky Director 10/29/1908 Usual Residence of Deceden the Meryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours after death with 1 and of Health and Mental Hygiene.
Ant: If New 27 is marked other than "natural", or items 23s or 1 any or other than the Western Residual Process. r than "natural", or items 23a or the Medical Examiner must be 404 Crocker Street 21014 United States Funeral 11 Maritel Status 12. Was Dacadent Evar in U,S. Armad Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White p 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration Supervisor 18. Mothar's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be Martha Blanton Stokley Osborne 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) Martha Lynn King / Daughter 404 Crocker Street Bel Air, Maryland 21014 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State permit. Pege Department of Important: If any injury or Parkwood Cemetery 5/17/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road Bel Air, Maryland 21014 Mark combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, onlying cluse on each line. 23a. Part1. Enter the disaasa, or con shock, or heart failure. List only Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical EDIO STAGE Severe Alzlainers Didecne 4 pour Examiner Examiner physician end the burial-transit requiras thet tha death certificeta be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of): 80 use signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2 No 3 Probably 4 Unknown 1 Yes by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s certificata has 2 DA 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Netural aftar death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 6 4 Homicide within 24 hours a To the Funeral (completaly filled Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier pletaly 1 (Check only one) 94 29b. Signatura and title of certifier 29d. Date signed (Month, Dev. Year) My

State Registrar

31. Date filed (Month, Dey, Year)

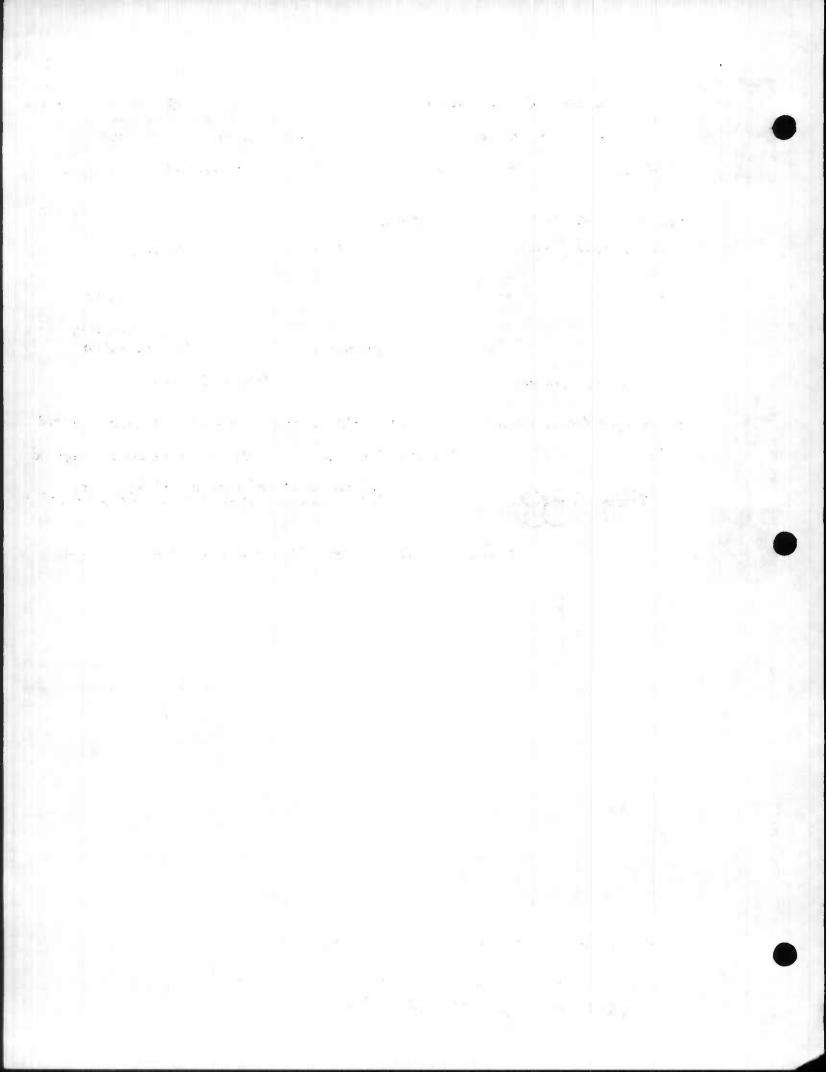
MAY 1 8 1999

32. Registrar's

DAUD

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

e m 6/5 marthail rd Prel ten bel 2/2/4
32. Registrar's Signature G. Sparks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month CLARA AKEHUrsT - 6 MAY 0 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 9923 Bird If Under 1 Year If Under 24 Hrs. BAUTIMORE RIVER RIVER Birthplece (Stete or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Days Hours 1 M 2 4 Yrs 60 212-36-623 8, 1938 MD Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐No MD BALTIMORE DUNDACK 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code U.S.A RD 21222 8478 COVE 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 Ho If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12+1 Shirt, Co. FASPECTOR NIA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) CLARA Milton E. M. EVANS House 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr James W. Akehurs T. SR. 8428 Cove BALTO. MD 21332 RD 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) cemeTery 5/15/99 RIVER. MIDDLE 21. Signet ve of Funerel Service Licansee HARTLEY Miller Forered Home 22. Name and Address of Facility Wille aller Harford RD BALTO MD 7527 23a. Perty. Errier the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete tntervel Between Onset and Death Immediate Cause (Finel Concar diseese or condition resulting in deeth) LUNG Due to (or es e consequence of) Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest Due to (or es a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contributa to the causa of death? Pert tl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 1 Nos 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? 1 ☐ Yes 2 No 1 Yes 20 No 25. Was case referred to medical 26. Plece of Death (Check only one) DAUGHTER'S Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 1 Dinaturel 28e. Date of Injury (Month, Day Year) 28c. injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

The law requires that the deeth certificate be axecuted Division of Vital Records, P.O. Physician: or Attending Hospital

Physician-

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinat

Physician /Medical

Examiner

signed by the ettending physician end d be deteched for use es the burial-transit

certificate has been si rector, page 2 should

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24 hours efter Funeral Dire

Physician/Medical Examiner

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Certification:

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29a. Certifier

(Check only one)

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Funeral

by

deeth with the Maryland

To the Hosp within 24 hou To the Fune completely fi

State Registrar

29b. Signature and title of certifier 30. Neme and a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Dey, Year)

of person who completed cause of death (Item 23a) (Type, Print)

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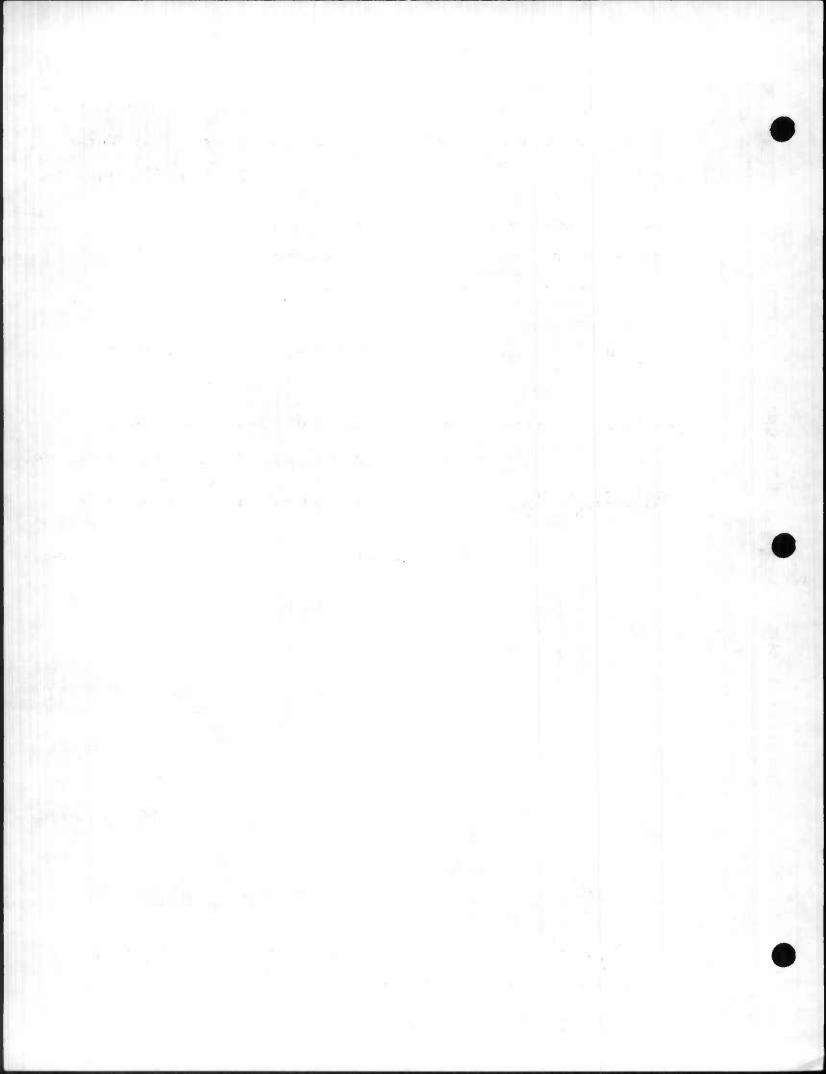
+ 206 BALTO Hospital 6830

MYO MINNIN 21737

31. Dete filed (Month, Day, Year)

Drive 32. Registrer's Signature

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 1999 16, Donald Edward Brooks 7:45 AM May /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1739 Wilkens Avenue | H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | MAR 6, 1929 Raltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Yrs 223-30-2307 70 Virginia Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limita ir than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 1739 Wilkens Avenue 21223 USA Funeral 12. Was Decedent Ever in U,S.

Armed Forces?

1 □ Yes 2 □ No Korea
If Yes, Give
Yeer or Detea: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. filed within 72 hours efter 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: White ð 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Residental Painting Painter permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important; if item 27 is merked other any injury or other treumstic event pace. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Green Brooks Unk. 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Louk/daughter 4323 Alan Dr. Apt. E Baltimore, MD 21229 20b. Plece of Disposition (Neme of cemetery, crematory or other piece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State Metro Crematory, Inc. 5/18/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee ²²Name and Address of Facility Cremation Society of Md., Inc. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner The law requires that the death certificate be executed physician and s the burial-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequenca of): USe P.O. Part tt. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 3 been signed the should be determined to Records, by Be Completed 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1□ Yes 2MNo 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: 25. Was case referred to medical 26. Pleca of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of tnjury (Month, Dey Year) 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death we Funeral Director: A pletely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 2 Madical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signative and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D29071 May 17, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 Α. N. Eutaw Street Baltimore, MD 21201 Ravi Krishnan,

State Registrar

DHMH 16 Ray 6/95

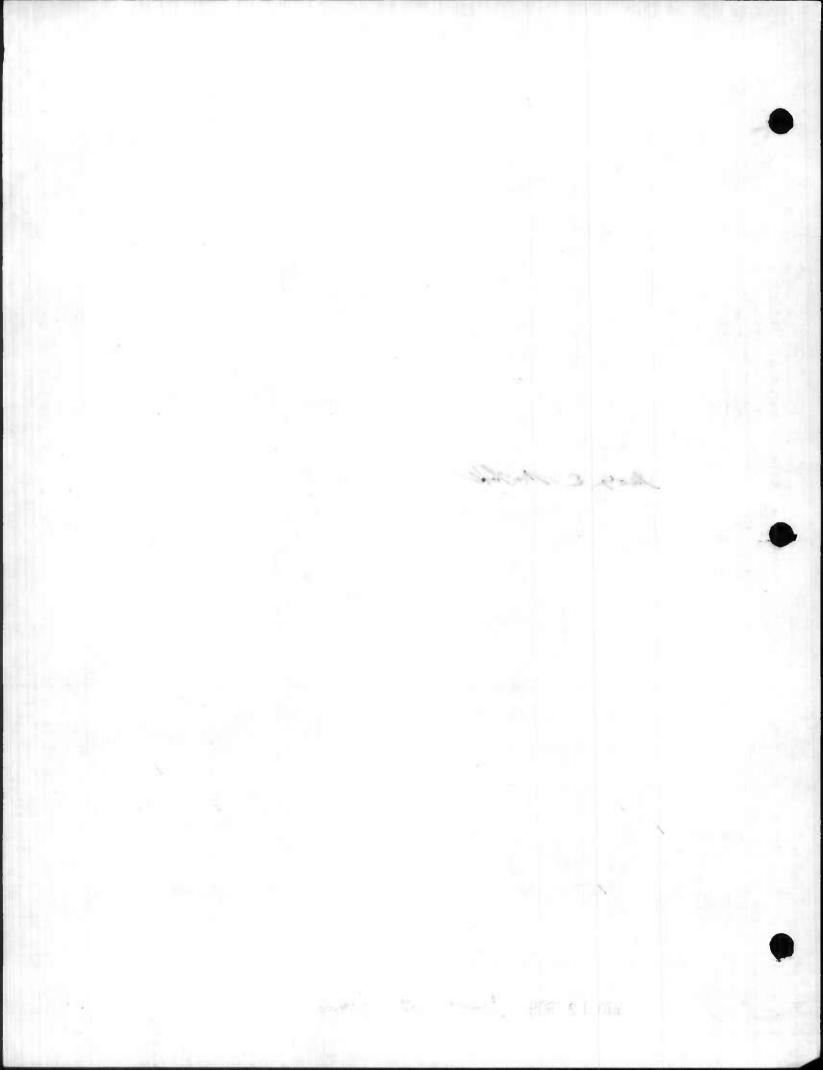
31. Dete filed (Month, Day, Year)

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M.D.

32. Registrar's Signature

2 person



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Wisit BOONN 4b. City, Town, or Location of Death 1999 1601 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Nov. 3 1947 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 180 M 2 F Months Days Hours 51 Thailand 036-40-3577 Yrs. Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Lutherville MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 3 Treadwell Ct. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Status 1 Nevar Married 2K Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plastic Surgeon Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Boonnumsirikij Kriang Keow Guay 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mrs. Pornpilai Boonn/ Wife 3 Treadwell Ct. Lutherville MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State Towson, MD. Hilltop Service Co. □ Donation 5 Other (Specify) 5/17/99 21. Signature of Funaral Service License 22. Name and Address of Facility Ruck Tows 1050 Yorl Towson Funeral Home York Rd. Towson, MD Inc. 21204 1a 23a. Part. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, the heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (on as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use centribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Secondos 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DNo 1 ☐ Yes 2 ☑ No 1 🗆 Yas 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 2 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed Box 68760. Completed by Physician/Medical the USB 85 Division of Vital Records, P.O. or Attending Physician: funeral director, Be Medical Certification: To After this after death.

Physician

/Medical

Examiner

Funeral

Director

Nerse 23e or 23e-f show one must be notified at

the Medical Examiner

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Hygiene.

Pages 1 and 2 should be fill ment of Heelth and Mental Mantal Mantal Mental Men

Physician 1 /Medical

Examiner

Director

Funeral

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Completed

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filed within 72 hours after

Baltimore, Maryland 21215-0020

25. Was case referred to medical

examiner?	lo
27. Manner of Death	5 Pending

5 Pending investigation 6 Could not be 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and titla of certifier

MAY 1 8 1999

29c. Licanse number

29d. Date signed (Month, Day, Year)

30. Name end addrass of person who comted cause of death (Item 23a) (Type, Print)

RES-000

Kiabsh 31. Data filed (Month, Day, Year)

M 32. Registrar's Signature

Emercenon Reportment

State Registrar

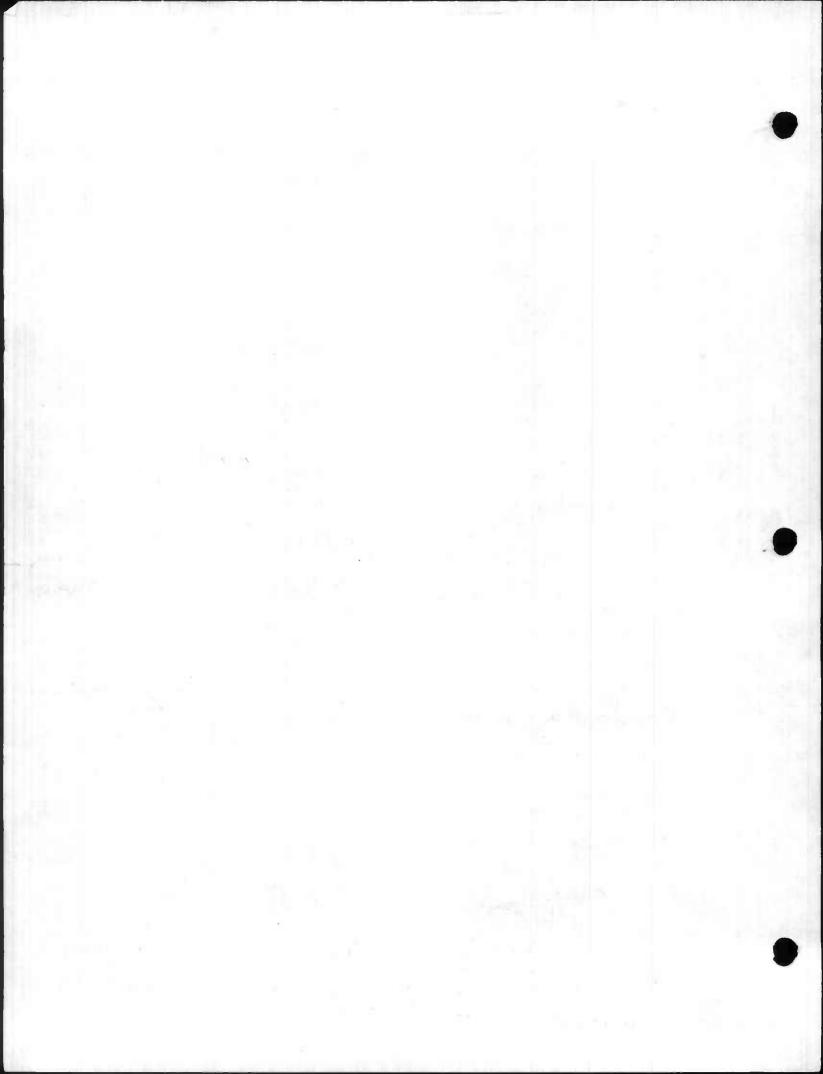
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Wilbert Barker May 12 1999 12:30PM /Medical 4e Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□_XM 2□ F Months Days Hours 215-10-5852 84 Yrs. Director Maryland Usual Residence of Deceden 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD Baltimore Phoenix 1 ☐ Yes 2 ☐XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21131 USA 1 Jackson Manor Ct. Nema 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Dives 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: WWII Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Tool Designer Martins 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be nemit. Pages 1 and 2 should be bepartment of Health and Mental reportant: If hem 27 is marked or John Barker Gertrude Hardesty 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Irene Barker/Wife 1 Jackson Manor Ct. Phoenix, MD. 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stele 5-17-99 Pikesville, MD. Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature, of Funegal Service Ligenser 1050 York Rd. Towson, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical End-Stage Dementia Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should I Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpice Certification: To 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending investigation death. 1 Yes 2 No Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Directions of the Polytine of the Po 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only one) To the I

D.m.

1999

Maryland 21215-0020

the death certificate be executed

John Barker

Records, P.O.

of Vital

Division Hospital or Attanding

DHMH 16 Rev 6/95

State

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Tariq Mahmood,

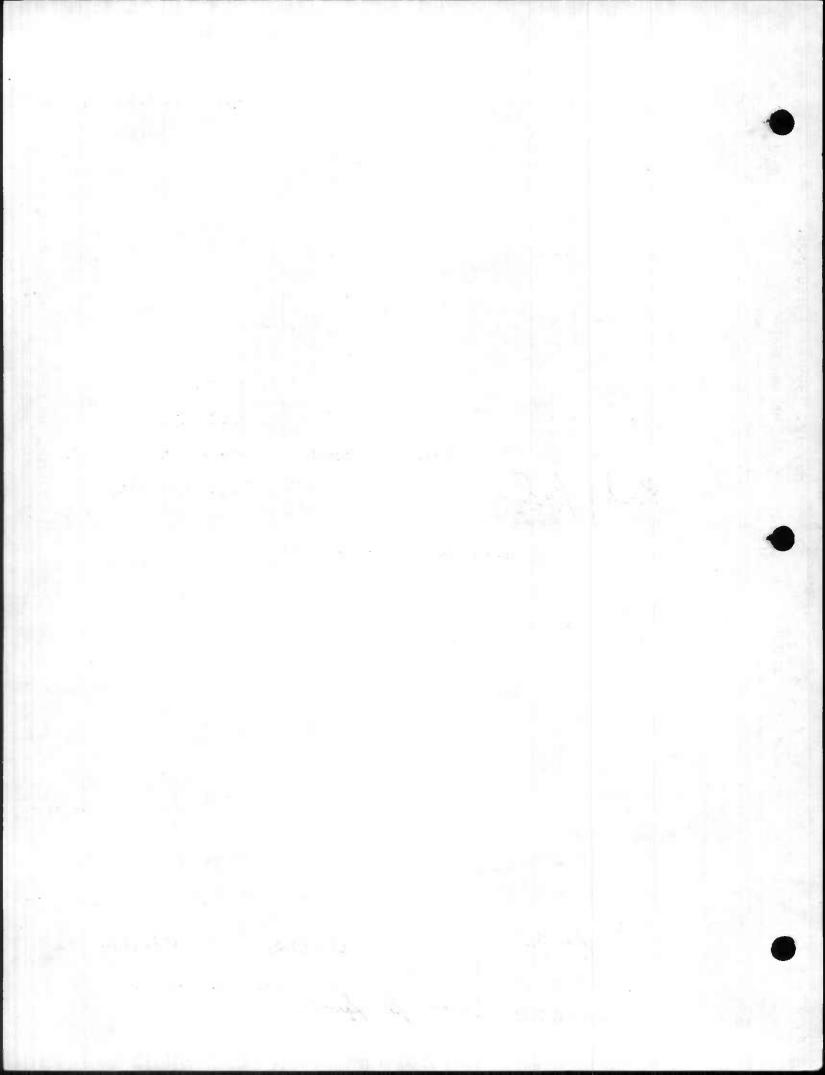
MAY 18 1999

29c. License number

43725

2300 Dulaney Valley Road, Timonium, MD 21093

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 5844 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 17^{Pey} May **Physician** 10:50 AM Ernest A. Belt /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3647 Ash Street Baltimore Baltimore City 8. Dete of Birth (Month, Dey, Year) May 15, 1 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Min 11 M 2□ F Months Deys Hours 68 220-28-8376 Yrs. Director Maryland Usuel Residence of Deceden the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits show 7 le marked other than "natural", or Nems 23a or 28a-f shov traumatic event, the Modical Examener must be notified at Baltimore 1 Yes 2 No Director Baltimore, City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3647 Ash Street U.S.A. 21211 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Dates: 1952-54 Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian 11. Maritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiane.
nt: If Nem 27 Is marked other than "natural", or Ne 1 Never Married 2M Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Tree Surgeon Arbor/Agriculture 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) George Armstead Belt Mary Writ 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3647 Ash Street Baltimore, Maryland Anna M. Belt - wife other 21211 20b. Plece of Disposition (Neme of cemetary, crametory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Method of Disposition

10 Burial 2 Cremetion 3 Removel from State Evergreen Mem. Gardens 6 permit. Page Department o Important: If any Injury or May 20, 1999 Finksburg, Md. 22, Name end Address of Facility 21. Signature of Funerel Service Licensee Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills Md. a mode of dying, such as cardiac or respiratory errest. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feiture. List only one cause on each line. Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final (wo years diseese or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner requires that the death certificete be executed pue -fran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lesf Due to (or es e consaguence of) -ieind Records, P.O. Box 68760, physician Physician/Medical the Due to (or es e consequence of) 98 950 0 signed by the a 23b. Did tobacco use contributa to the cause of death? Pert ff. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 9 24b. Were eutopsy findings evelleble prior to complation of causa of death? Completed 24e. Wes en eutopsy peen has paga 2 20 No 1 TYas 2 No 1 T Yes certificata Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: Aftar this certifice director, 25. Wes case referred to medical Be 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA funarai 27. Mannar of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steled. edicai 29e. Certifier To the I within 2 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certified 29c. License number 30. Name end address of person who complated cause of death (Itam 23a) (Type, Print),

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Kushne

32. Regisfrer's Signeture

Jonathan 31. Dete filed (Month, Day, Year) MAY 1 8 1999 Suite 208 Elabora

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State Registrar

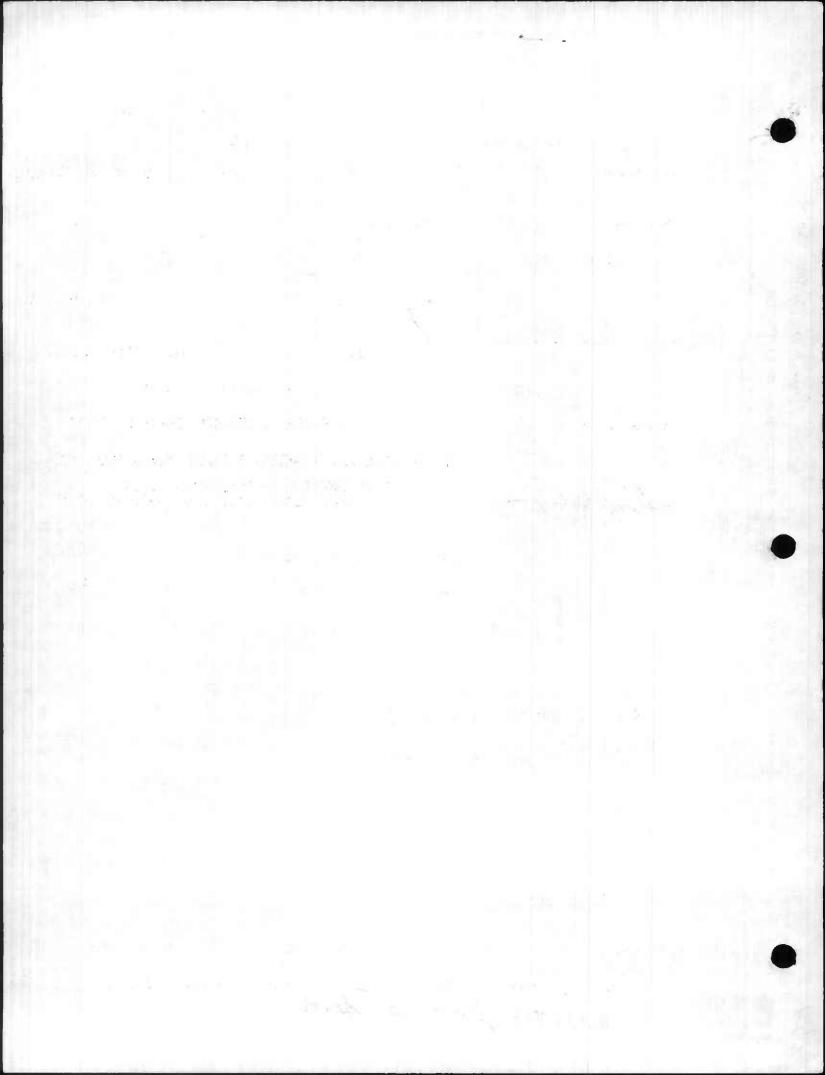
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32. Register's Signeture DAVED PARVER, SENA 31. Dete filed (Month, Bay, Year) MAY T 8 1999

2401 West Belvedere Avenue

Baltimore, Maryland 21215



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Neme (First, Middla, Last) 2 Data of Death 3. Tima of Death **Physician** JOSEP# BOXDALE 3:20 PM MAY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore BOW Secoups hospital If Undar 1 Yeer | if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) JULY 1, 1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** Days 1 M 2 F Yrs. 219-30-6853 59 BALTIMORE, MD. Director Usual Rasidanca of Dacedant Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mentel Hygiene.
Intt: If Itam 27 is marked other than "natural", or items 23s or 28s-f ahow ary or other traumatic event, the Medical Evant entre the notified as 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND Directo BALTIMORE 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code USA 1918 W. FRANKLIN ST. 21223 Funeral 12. Wes Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: AFRO.AMERICAN þ 3 Widowad 4 Divorced Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade complated) Elamantery/Secondary (0-12) College (1-4or 5+) JANITOR BALTIMORE CITY 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) ANDREW BOXDALE ANNIE BOXDALE 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) 1918 W. FRANKLIN ST, BALTIMORE, MARYLAND 21223 GWENDOLYN BOXDALE DAUGTHER 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Removal from Stata Department of Important: If any Injury or 4 Donation 5 Other (Specify) WESTERN STAR CEMETERY 5/19/99 CATONSVILLE, MD. 22. Nama and Addrass of Facility
ESTEP BROTHERS FUNERAL SERVICE, P.A.
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21. Signature of Funeral Sarvica Licansaa ESTEP Pert1. Entar the disease, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or respiretory errest, shock, or heart faitura. List only ona cause on each lina. 21217 Approximete Intarval Batween Onset end Deeth **Physician** /Medical Immediata Cause (Finel diseesa or condition resulting in death) Examiner Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest eum ou Division of Vital Records, P.O. Box 68760, requires that the deeth certificate be Physician/Medicai Dua to (or es e consequance of): 88 esn signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performad? complation of cause of death? page 2 s certificate or Attending Physician: funeral director, Be 25. Was casa raferrad to madical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Data of injury (Month, Dey Year) 27. Mannar of Deeth Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 2 Accidant 5 Panding after death. 1 Yas 2 No invastigation 6 Could not ba datarmined 3 Suicida 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral D Hospital Certifying Physician: To the best of my knowladge, deeth occurred at the time, date end plece, end dua to the ceuse(s) end mannar as stated.

Medical Examiner: On the basis of axamination end/or invastigetion, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) and mannar stated. 29a. Certifier Medicai (Check only one) To the Within 2 To the I 29b. Signature and title of certifiar 29c. Licansa number 29d. Dete signed (Month, Day, Year) Bull I hours D26256 30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

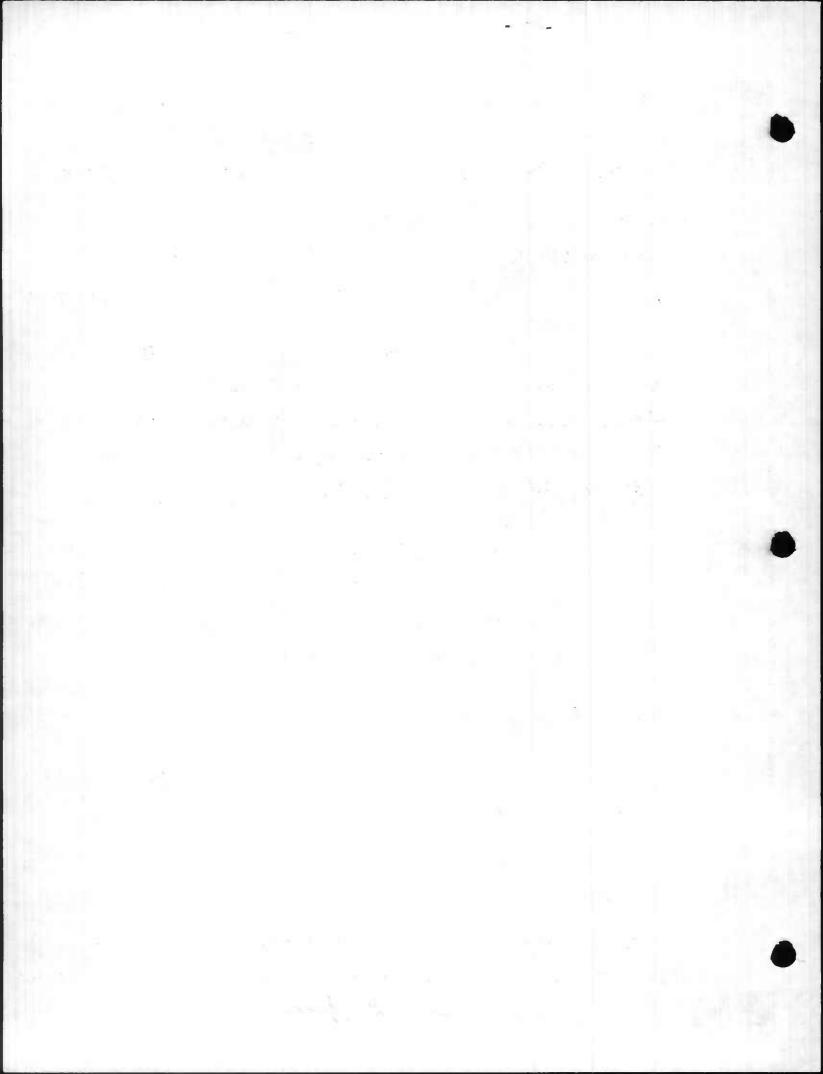
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State Registrar

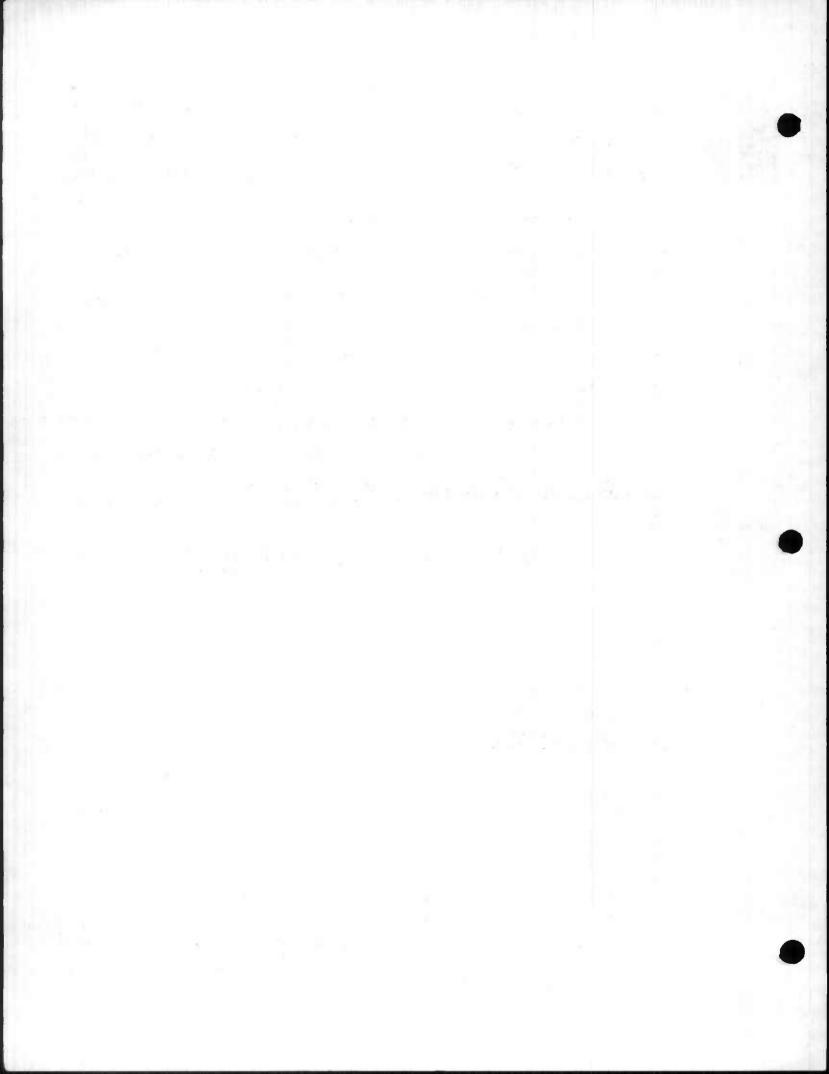
31. Date filed (Month, Day, Year)

32. Ragistrar's Signature

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Physic	ian		-					2. Date of Dea Month	Day	Year	3. Time of Death		
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r 28	Director	10e. Street and Number	Zip Code		1	10g. Citizen of What Country?							
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permit. Peg Department Important: I any Injury o		21. Signeture of Funeral Service Lice	J. She	annor	HUBBA	RD FU	ss of Facility INERAL HOM ENS AVENUE		TMODE	MADVI	AND 2122		
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	Be	25. Was case referred to medical					26. Place of Death	(Check only or	ne)				
Ø 00 10	To	examiner?	Hospitel:	ient 2 ER/Ou	utpatient 3	DOA Oth				er (Specify)		
After fune		27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Inj (Month, D	ury 28b.	Time of njury M	28c. Injur Wor	y et :	28d. Describe h					
tal or Atthese selected in by the	Certification:	3 Suicide 6 Could not be determined	28e. Placa of In	ijury - At home, fa tc. (Specify)	irm, street, fact	ory, office	1	28f. Location (Si City or Town	treet and Numb n, Stete)	ber or Rural	Route Number,		
To the Hospital or Attentwithin 24 hours effer deatl To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exam	nyaician: To the best niner: On the basis of and menner s	of examination an	e, death occurre d/or investigati	ed at the tin	ne, dete and placa, a pinion, death occurre	and due to the co ed et the time, d	ause(s) end me lete and pleca,	enner as sta and due to	ated. the cause(s)		
To t with To t	M	29b. Signature act title of certifier	ru			9c. Licens	649	2	9d. Date signe May	d (Month, E	Pay, Year)		
		30, Name and eddress of person who	completed cause of 34	deeth (Item 23e)	(Type, Print)	us	649 Ar. (Balli	MEN	. MO	21229		
Sta	te	31. Dete filed (Month, Day, Year)	22. Regist	rar's Signature	2								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5848 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Physician Mildred Elizabeth Brady 1999 13 9:45pm May /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 904 Wiljacon Court Anne Arundel Millersville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jan. 26, 1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 200 F 215-30-2492 Yrs. 65 Baltimore, MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Millersville 1 Yes 2 No Directo 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 904 Wiljacon Court 21108 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indian, 11. Marital Status Bleck, Whita, etc. 1 ☐ Yaa 2 X No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary-Computer Operator Tax-Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Abraham Amass Laura Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Leo Brady (Husband) 904 Wiljacon Court, Millersville, MD 21108 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date **1** Burial 2 □ Cremetion 3 □ Removel from Stete Cedar Hill Cemetery 05/21 Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Hardesty Funeral Home, P.A. lutta 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) 3 years Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): edical Due to (or aa a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes ANO 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 No 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 | Yes 2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. tnjury at Work? Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

Box 68760 P.O. Records, **Funeral**

Director

show

r than "natural", or items 23a or 28a-f the Medical Examiner must be notifie

with the Maryland

filed within 72 hours after

Hyglene.

permit. Pages 1 and 2 should be filed 1.
Department of Health and Mental Hygles important: if tem 27 is marked other 18 any follury or other traumatic event, the 200s.

Physician

/Medical

Examine

physician and s the burlei-transit

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After this

altimore, Maryland 21215-0020

Division of Vital Physicien: of Attending Father after the function of the function of the funer of To the Hospital or within 24 hours aft To the Funeral Discompletely filled in

> State Registrar

2 an 8 1999

29b. Signature and title of sentiller

29a, Certifier (Check only one)

mo

29c. License number 00029571

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

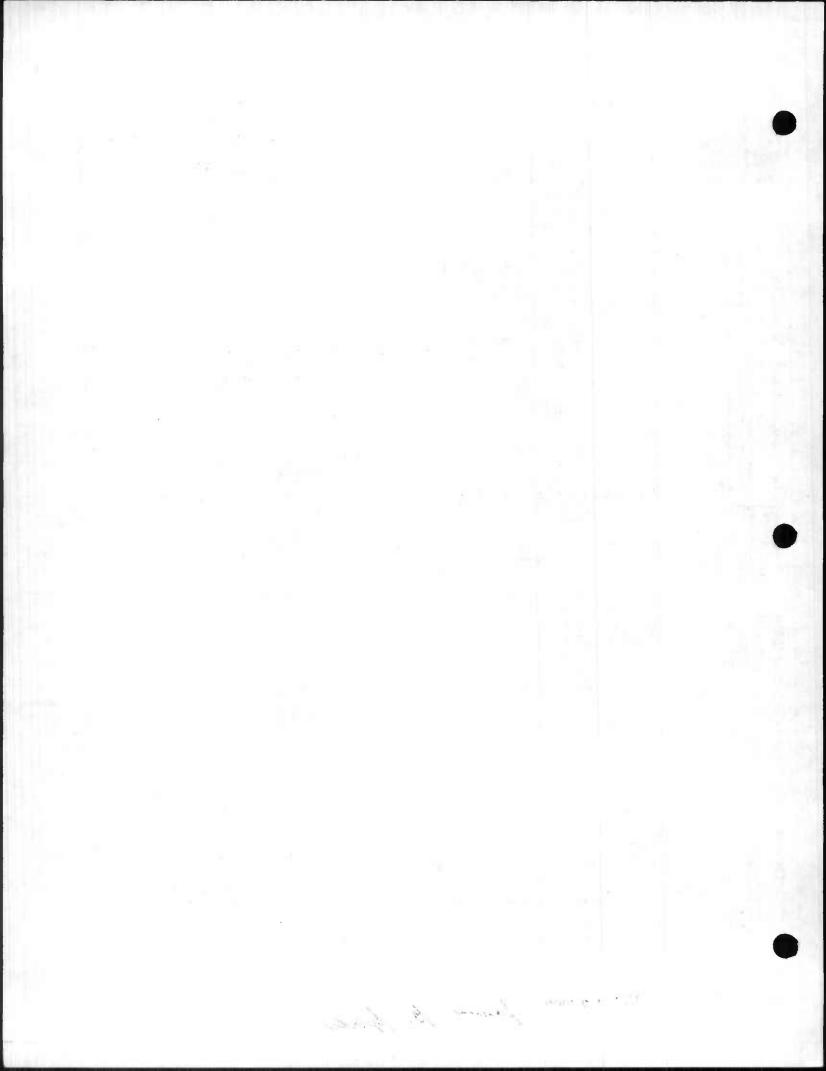
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date aigned (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1655

Blvd. sunt 101 Crofton MD 21114 Crotton

32. Registrar'a Signeture Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Jessie 100065 MAU :15pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mercux V 5. Social Security Number Baltimore Medicial Baltimore enter If Under 24 Hrs. 8. Date of Birth (Month, Dey. If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 2/3-/16-9/93 Usual Residence of Decedent 1 ■ M 2 X F Yrs. Director the Maryland 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar frust to notified at Yes 2 No Director MARYLAND 10e. Street and Number lpg. Citizen of Whet Country? 309 2 AVENUE ANT Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 72 hours efter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: P 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Inlury or other traumatic event, in the Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC WORKER PRIVATE UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) SUSIE GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 9529 OAKTRACE WAY, RANDALL STOWN, 140.2/133
ce of Disposition (Neme of Date 20c. Location - City of Town, Stete EDIE FROIX (GRAND DAUGHTER) 20e. Method of Disposition

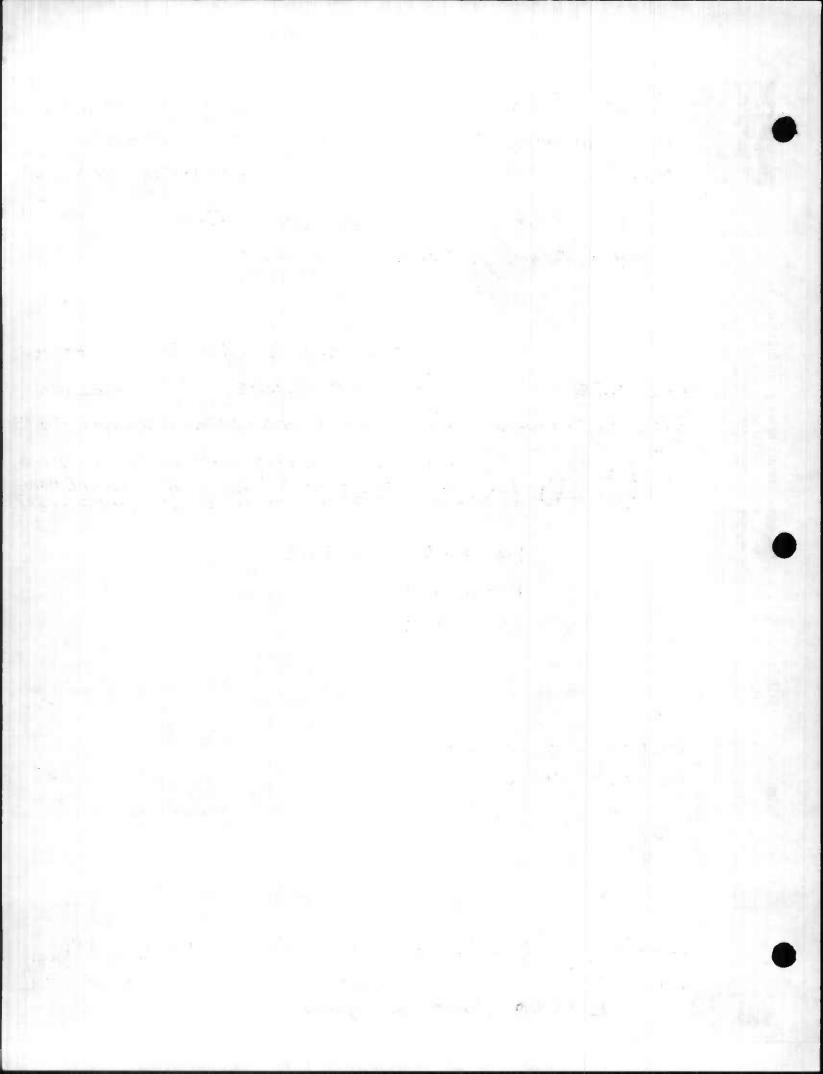
1 ■ Burial 2 □ Cremetion 3 □ Removel from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) CEMETERY 05-20-99 LAUREL, MARYLAND 4 Donetion 5 Other (Specify) NATIONAL 22. Name end Address of Fecility

JOSEPH H.

2148 N. FUL of Fa ural Service Interesee any Ir BROWN JR. FUNERAL 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest/shock, or heart failure. List only one cause on each line. Mp. 21217 Approximete tnterval Between Onset end Death **Physician** Failure /Medical Immediate Cause (Final disease or condition resulting to death) Examiner Examiner monia physician end the burial-transit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or tnjury that Initiated events resulting in death) Lest Due to (or as a consequence of): ASDIVATION Physician/Medical Due to (or es e consequenca of): signed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown 3e0875 à 24b. Were eutopsy findings aveitable prior to completion of cause of death? ostcomyelits sacrum 24a. Was en eutopsy performed? Completed peen Failure to Thrive 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medicat examiner? Be 26. Piece of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how tnjury occurred Certification: After 1 Neturel 5 Pending investigation ne Hospital or Attending n 24 hours efter death. ne Funeral Director: Afte 1 Yes 2 No 2 Accident 3 Suicide 6 Coutd not be determined To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by it 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) mid. 2573 Cleanleigh Drive Bult mo 30. Name end eddress of completed cause of deeth (Item 23e) (Type, Print) J. 3 mmors - Gemmons 32. Registrar's Signature 31. Date filed (Month,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth IRENE BOLDEN 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number, Baltimore City Taryland 5. Sociel Security Number 7. Age (In yrs. Jast birthday) If Under 1 Yeer If Under 24 Hrs. 9. Birthplace (State or Foreign Country) VIRGINIA 1 M 2 F HNKNEWN Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No MARVLAND 100. Citizen of What Country? 10e. Street end Numbe 7/2 NEWINGTON AVENUE USA 121 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MOSES ANNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) (SON BOLDEN BALTIHORF, MD. 2/2/7 20c. Location - City or Pown, State 712 NEWINGTON AVENUE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 05-20-99 LANSDOWNE, MARYLAND 4 □ Donation 5 □ Other (Specify) ZION CEMETERY 22. Name and Address of Facility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIHORE, MD. 2121 21 Sig FULTON AVE., BALTIHORE, MD. 21217 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, ir heert failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of death? 2 00 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

Physician /Medical Examiner

The law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

b

hams 23a

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Health and Mental

Pages 1 and 2 should

altimore. Maryland 21215-0020

Director

Funeral

by

Completed

Examiner physician and s the buriai-tran Physician/Medical use as attending | signed by I þ Be Completed pege 2 director. 2 To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral Certification:

peeu

After this cartificate has

25. Was case referred to medical examiner? 1 Yes 2 No

29a. Certifier

(Check only

27. Menner of Death 1 Netural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be determined 4 Homicide

1 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. one 29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

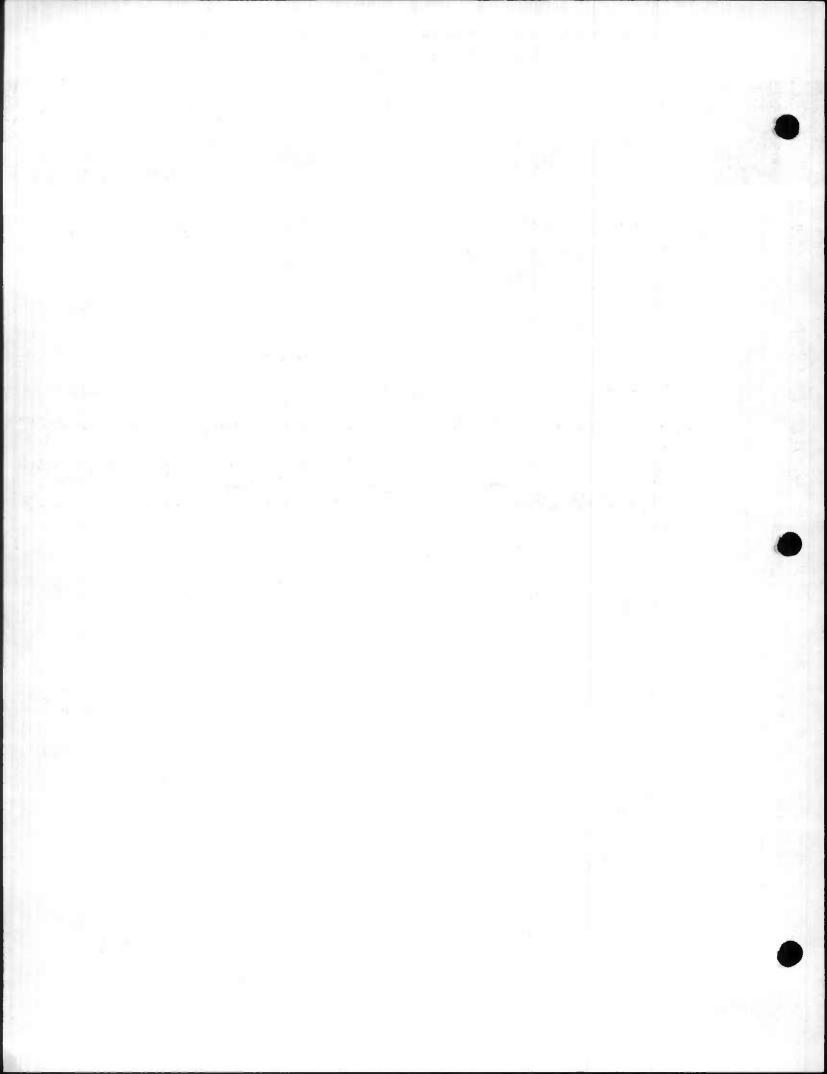
30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Jakyland

32. Registrar's Signature

State Registrar

Medicai



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 14 Day Day 9 9 9 9 Blair Physician 0400 Tygond amont /Medical 4a Facility Name (Pnot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (enter Arundel Annapolis Anne Arudel Medical H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 150M 20 F Months lary and Director Usual Residence of Deceden 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Nerns 23s or 28s-f show Arundel Annapolis 1 XX 2 No Anne Director lary land 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Avenue United States Tyler 21403 death 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No of Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status pemil. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiens. Important: if Item 27 is marked other than "netural", or hen any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Specify: Black Baitimore, Maryland 21215-0020 1 Yes 200 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Blair ddie Gilmore Charlinda Vvette Lamont 19a. Informant's Name/Relationship (Type, Print) Charling Yvette Blair 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Yvette 1374 Tyler Ave Charlinda Annapolis, Md 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Schemation 3 Removal from Stata letro Cremoutory Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwe Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical hour 22 minutes Examiner Examiner unknown physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, In competen Physician/Medical signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 0 1 □ Yes 2 No this cartificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartifica completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 8 No 100 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State

DHMH 16 Rev 6/95

29a. Certifier

29b. Signature and title of certified

31. Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Itardart

32. Registrar's Signature

2001

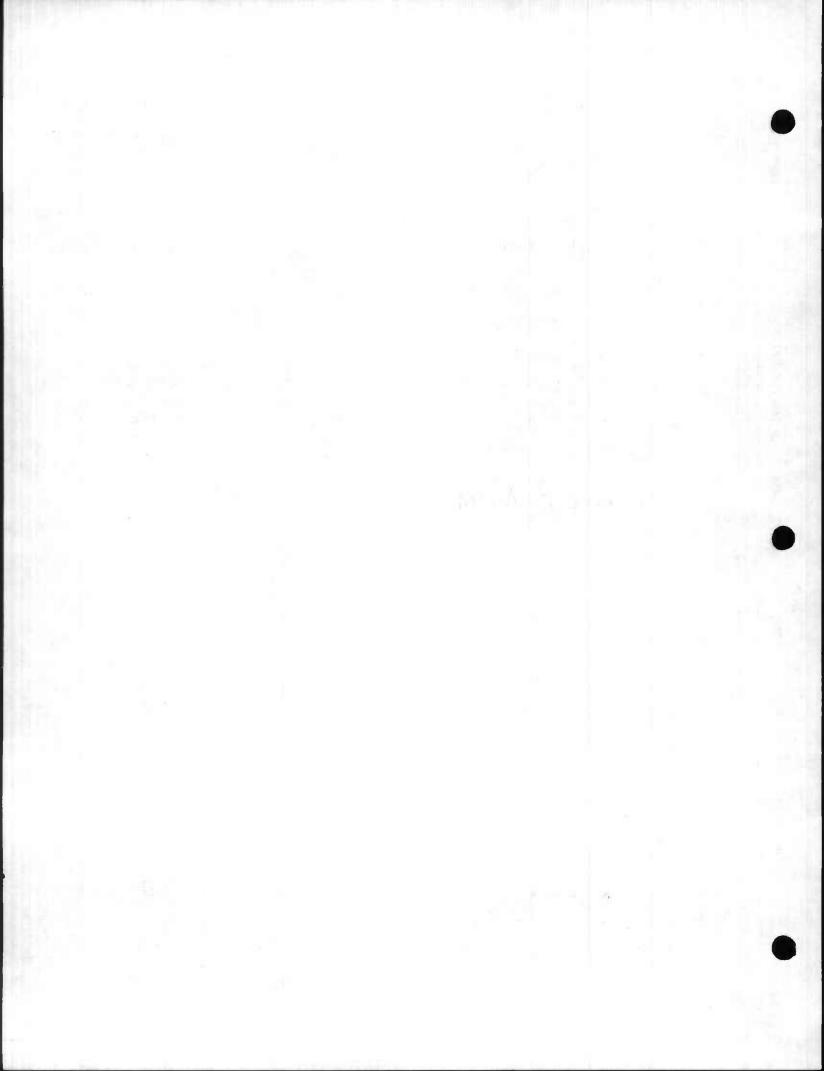
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0053246

29d. Data signed (Month, Day, Year)

medical Parkway, Annapolis Manyland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				Ce	ertificate	of	Death			Reg. N	lo.	7	2027
The second second	a (First, Middle, La ARD L.		K						2. Date of De Month MAY		, 199	Year 99	3. Time of Death 6:30 PM.
4e Fscility Neme (If not institution, giv	e street end nu	mber)			T	4b. City, To	wn, or Lo	cation of Deat	h 4	c. County	of Death	
5019 F	HARFORD R	D.					BZ	ALTIN	1ORE		N	/A	
5. Sociel Security N 214-80	-0321	Sex IXM 2□F	7. Age (In yrs. 25		Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 7 / 1	W. Yes	73	9. Birth Cou MD	place (Stete or Fore ntry) •
Usuel Residence of			1.0.0	-									
10a. Stete MD	10b. County	ocation LTIMOI	RE							10d. Inside City Limi 108Yes 2□1			
10e. Street and Nu	mber				10f. Zip (Code				10g. C	itizen of	What Cou	ntry?
5803	MOORES	RUN CO	URT			21	206			J	J.S.	Α.	
11. Marital Status 103 Nevar Marri 3 Widowed	ied 2 Married	l,S. 13.	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2万No Specify: Specify: WI						ck, White,				
(Spec	15. Decedent's Ed	ducation		16a. Dece	edent'a Usuel	Occup	pation during mas	t of work	ina	16b.	Kind of B	usiness/Ir	dustry
Elementery/Seco 1 2		life.	iile. DO NOT use retired) STEAMFITTER UNION										
	(First, Middle, Last, LTER BI	18. Mother's Name (First, Middle, Maiden Sumame) MONICA WIECIECH											
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	position Cremation 3 = 5 Other (Specif		Stete	cem <i>etery</i> , cre	osition (Name Internation of other	ner ple		ME J 5	Date 5/19/9				own, State MD.
21. Signeture of Fu	neral Service Licer	Kaen,	1000	/ K		ROM	SKI I	UNE	RAL H			-	. 21222
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Physician /Medical Examiner

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been signed by the should be detach

page 2 s

Medical Certification: To Be

(Check only one) 29b. Signeture end title of cer

31. Date filed (Mont)

After this certificate

eral Director: After thi filled in by the funeral

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certified

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examine

1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed? Partial 1 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

1 TYes 2 □ No AT

SCENE

25. Wes cese referred to medical axaminer?

\$\tilde{V} \tilde{V} \ Hospitel: Other: 4 Nursing Home 5 ☐ Residence 6 💆 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 5 Pending investigation 1 Neturel subject Shot 30 -14-99 1 Yes 2 ₹No 2 Accident 11 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcida 4 ☐ Homicide

28e. Plece of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 29a. Certifier

5019 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and prenner steted.

MAY

29d. Date signed (Month, Day, Year) 15, 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

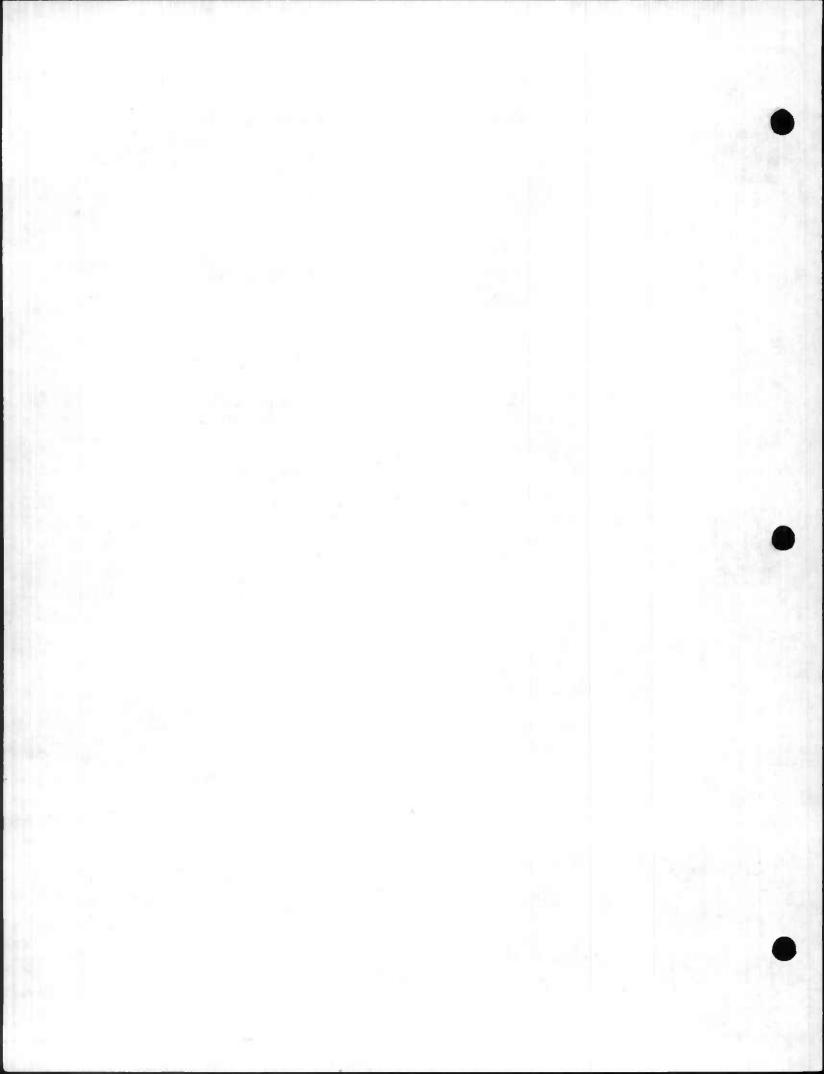
111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29c. License number

State Registrar

Fowler Dey Year) 32. Registrer's Signeture

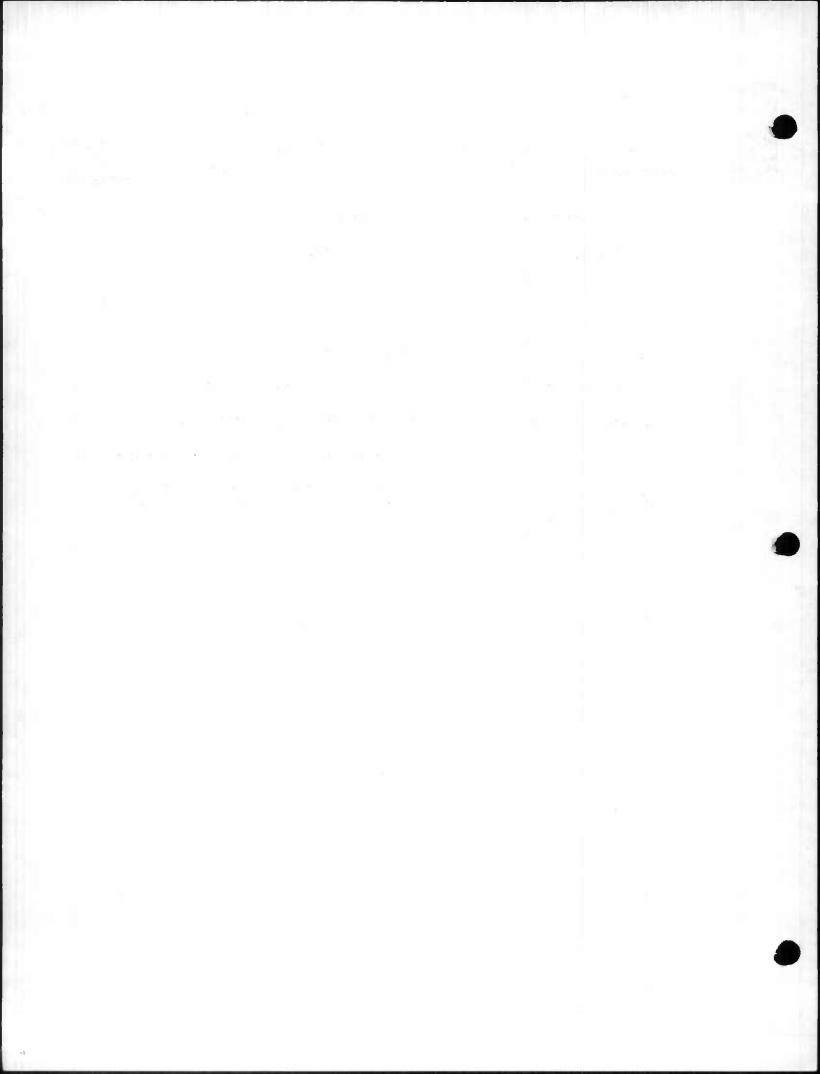


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryla		ificate of			Reg. No.	15853			
Physician /Medical	00000011110110					2. Data of Da Month May	Day 15, 199	Yaar 9 3:10am			
Examiner	An Chalife Manne (Mant Institution at				46. City, Town, or L Annapoli		Death 4c. County of Death Anne Arundel				
Funeral Director		Sax 7. Aga (In yrs 1 □ M 2 □ X F 84	. rator on manay/	If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da Jaunua	th ny, Year) nry12,19	9. Birthplace (Stata or Foraig Country) 15 Maryland			
show det	Usual Rasidance of Dacedant 10a. Stata 10b. County Carro		City, Town or Local					10d. Insida City Limits			
utier death with the Maryland in terms 23e or 28s-1 show inner must be notified at Funeral Director	10e. Street and Number 6313 Georgetown				Vhat Country?						
ire, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours after death with the Manyland I health and Mental hygiene. Itam 27 is marked other than "natural", or items 23e or 28=1 show other traumatic avent, the Medical Examinations be notified at To Be Completed by Funeral Director	3 XWidowed 4 □ Divorced	12. Was Decedant Evar in Armad Forcas? 1 Yas 2 No If Yes, Give Yaar or Datas:		as Decedant of H /as, specify Cub	ice - Amarican indian, ack, Whita, atc. White						
Aaryland 21215-0020 2 should be filed within 72 hours aft and Mental hygiene. Is marked other than "natural; or "aumatic avent, the Medical Exam To Be Completed by F	15. Decedent's E (Specity only highast gr	ducation ada complated) Collaga (1-4or 5+)	(Giva kii lifa. DC	16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Homemaker 16b. Kind of Business Own Ho							
Maryland 212 32 should be filed within and Mental Hygiene. 7 is marked other than traumatic avent, tree. To Be Comp	17. Fathar's Nama (First, Middla, Lasi)			18. Mothar's Nama (First, Middle, Maidan Sumama) Laura Catanzaro						
Mary and 2 should alth and 3 27 is may be traume	19a. informent's Neme/Ralationship Mary L. Blevins					or Rurel Routa Number, City or Town, Stata, Zip Coda) . Airy, Maryland 21771					
	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cramation 3 🗈 4 🗆 Donation 5 🗀 Othar (Speci	Jhailiovai Iroili Stata	Place of Disposit camatary, crama New Catl	isposition (Nama of cramatory or other place) Cathedral Data 20c. Location - City or To 5/18/99 Baltimore,							
Baltimo permit. Page Department o Important: if eny injury or	21. Signatura of Funaral Sarvice Lice Robert Are	nsaa Bula		Nama and Addra	**			omes, Inc. e, MD 21228			
Physician /Medical	23a. Pert1. Enter the disease, or conshock, or heart failure. List only					or raspiratory a	rrast,	Approximata interval Batween Onset and Daath			
Examiner	Dua to (or as a consequence of):										
ificate be executed ificate be executed physician and as the bunal-transit		Dua to	(or as a consaque	ance of):	thy per les	you,		> months			
= 0.6	rasulting in death) Last		(or as a consequa	ance of):		mon th					
tha de tree de	Part II. Other significant conditions	contributing to daath but not ra	asulting in the und	larlying causa giv	van in Part I.		tobacco uae co	ntribute to the cause of death			
Physician: The law requires the this cartificate has been signed rel director, page 2 should be deleted by P.: To Be Completed by P.						24a. Was	an autopsy ormed?	24b. Wara autopsy findings available prior to completion of cause of death?			
yelcien: The law is cartificate has director, page 2							Yas 2⊠ No	1 □ Yas 2 Þ No			
Physician: this cartifical director,	25. Was casa rafarrad to medical examiner? 1 Yas 2 No	Hospital: 1 LInpatiant 2	☐ ER/Outpatient	3□ DOA Ott	26. Pleca of Dea		ona) idance 6 □Oth	ar (Specify)			
To the Hospital or Attanding Phy within 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral Medical Certification: T		28a. Data of injury (Month, Day Year)	28b. Tima of Injury	M 28c. Inju		28d. Describe how injury occurred 28f. Location (Straat end Number or Rural Routa Number, City or Town, Stata)					
the Hospitai of thin 24 hours a thin 24 hours a the Funeral Dempletaly filled impletaly filled Ce		hysician: To the best of my kr miner: On tha basis of axamin and manner stated.									
Within To the comple	29b. Signatura and title of certifiar	m D		29c. Licans	sa number 951437			d (Month, Day, Year)			
8	30. Nama and addrass of person who		em 23e) (Type, Pi 18173Y E		ARNNDE	mED.		ANNAPOLL			
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	netura	1							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			01 M A C :		Certific	ate of E			Reg. No.	15854		
Physic /Medi	cal	1. Decedent's Name (First, ME 1518	Bo	enkar	d	41	Olto Tours	2. Deta of D Month	/Z /	Year 3. Time of Deeth		
Examii Funeral Director	ner	4a. Fecility Nema (If not instituted by ALL Considered Security Number of 213–01–3539	Periatric C	enter Lnter 7. Age (In yrs. Ie 83	est birthday) If Un Yrs. Mont	der 1 Year	o. City, Town, or 17 DD LE 17 Under 24 Hrs Hours Min.	Rive B. Date of B	e BA	9. Birthpiece (Stete or Foreig Country)		
		Usuel Residence of Deceden								Maryland		
S hov	-	10a. Stete 10b. Cou		10c. City,	Town or Location					10d. Inside City Limit		
F S	Director	Md. Baltimore Essex								1 Yas 20 N		
23a or 3		10e. Street end Number 518 Dorse		10f.	Zip Code 2122	21		10g. Citizen of What Country? USA				
al', or iteme Examiner of	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ I 3 ☑ Widowed 4 ☐ Divor	daniEvarin U,S ces? 2 TootNo tes:	If Yes, s	cedent of His pecify Cuban 2 12 No	spenic Origin? (S n, Mexican, Puer Specify:	Specify Yas or N to Rican, atc.)	o- 14. Race Bleck	ce - Amarican Indien, ck, Whita, atc. White			
ilene. r than "natural", or items 23a or 28a-f show The Medical Examiner must be notfled at	Completed	(Specify only his Elementery/Secondery (0-1	dent's Education ghest grede completed) 2) College (1-	4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			16b. Kind of Busin				
d othe	To Be Co	7th 17. Fether's Neme (First, Mide Conrad N	die, Last) Jaseman									
in end Menta 7 is marked trsumatic e	1	19a. Informent's Neme/Releti			19b. Malling Addr	ess (Street e	nd Number or Ru	urel Route Numi	ber, City or Town,	Stete, Zip Code)		
5 5 5		Bill King /	cousin		3901 Da	rleigh	n Road	Perry	Hall Mar	yland 21236		
0 = 0		20a. Mathod of Disposition 1 Description 2 Cremete 4 Donetion 5 Othe	on 3 □Removel from S	tate Cer	ca of Disposition (I metery, cremetory of LAWN CE	or other plece		Date 7/99	20c. Location - Baltime	city or Town, State		
important: any injury once.		21. Signeture of Funeral Serv	ica Licansee	M	Conn	_	of Facility Funeral AVe. Bal			01		
Street and series of the principle of th	ai Examiner	Immediate Ceuse (Finel disease or condition resulting In deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events	e	Due to (or e	es e consequence We es e consequence	of): of): Vasu	acid		ean	Onset end Daeth		
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SO	Completed							1	Yes 2 DMG	completion of cause of deeth?		
pag		25. Was case referred to med	lical				26. Piece of Dec	eth (Check only	one)			
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is certificate director, pag	To Be	axeminer?			28b. Time of	28c. Injury Work	et ?	28d. Describe	how injury occurre	ed		
n. After this certificate funeral director, par	은	1 Yes 2 No 27. Menner of Deeth 1 Naturel 5 Per 2 Accident inve	28e. Dete of (Month)	, Dey Year)	Injury M	1 🗆 Y	es 2 No					
n. After this certificate funeral director, par	Certification: To	27. Menner of Deeth 1	28e. Dete of (Month) astigation ald not be ermined 28e. Pleas of building	of Injury - At hom g, etc. (Specify)	M ne, farm, street, fec	1 □ Yotory, offica	es 2 No	City or To	iwn, State)	er or Rural Route Number,		
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arier ceam. Director: After this certificate in by the funeral director, par	은	27. Menner of Deeth 1	28e. Dete of (Month) stigation uld not be ermined 28e. Pleca of building tying Physician: To the base and menner	of Injury - At homog, etc. (Specify) pest of my knowless of exeminetic	M ne, farm, street, fect ledge, deeth occurren en end/or investiget	1 Ye tory, offical ed et the time ton, in my opi	es 2 No	City or To	own, State) ceuse(s) and mer dete end plece, e	nner es stated.		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARY BARGAR SIS Ami 05 4a Facility Name (If no institution, give street end number) 4c. County of Death 4b. City, Town, or Location of Deeth MENCAL CENTER Frencholl'S APENEE ARUNEDGE Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 1 M 200 F Days 58 218-36-5620 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Anne Arundel **Annapolis** 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 130 Hearne Road 21401 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian. 11 Manital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) Anne Arundel County Elementary/Secondery (0-12) College (1-4or 5+) School Bus Driver Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Robert H. Creel Roselma Stewart 19a. informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Joseph A. Bargar, Jr. (Son) 1309 Hazelnut Court, Annapolis, MD 21401 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 05/17 Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. abuck 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) RESPERATORY FAILURE Due to (or es e consequence of): PulmonealE Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clored C OBSTRUCTURE LUNG POSTSE Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Miknown 1 Tyes 2 No DUABGIES MELLITUS 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 9 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

e filed within 72 hours efter al Hygiene. other than "natural", or Re

12 should be fi and Mental F is marked of

permit. Pages 1 and 2 st Department of Heelth and Important: If Item 27 is n

other

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Baltimore, Maryland 21215-0020

the Maryland

Examiner physician and the buriel-transit 50 USB ed by the s signed by t

certificate has After this funeral

Physician/Medicai by Completed Be

P

Certification:

edical

certificate be after deeth. Director: Aft 6

25. Was case referred to medicel examiner?

1 Yes 2 No

27. Manner of Deeth

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

CHROSTOPHERS

Box 68760. o Records, Division of Vital

> State Registrar

29b. Signature and title of compa

populing,

Hospital:

5 Pending investigation

6 Could not be determined

1 Inpatient

28e. Date of Injury (Month, Dey Year)

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

29c. License number mp 3/130

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

Location (Street and Number or Rural Route Number, City or Town, Stele)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) by FRANKLING ST AMARATICS

26. Plece of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

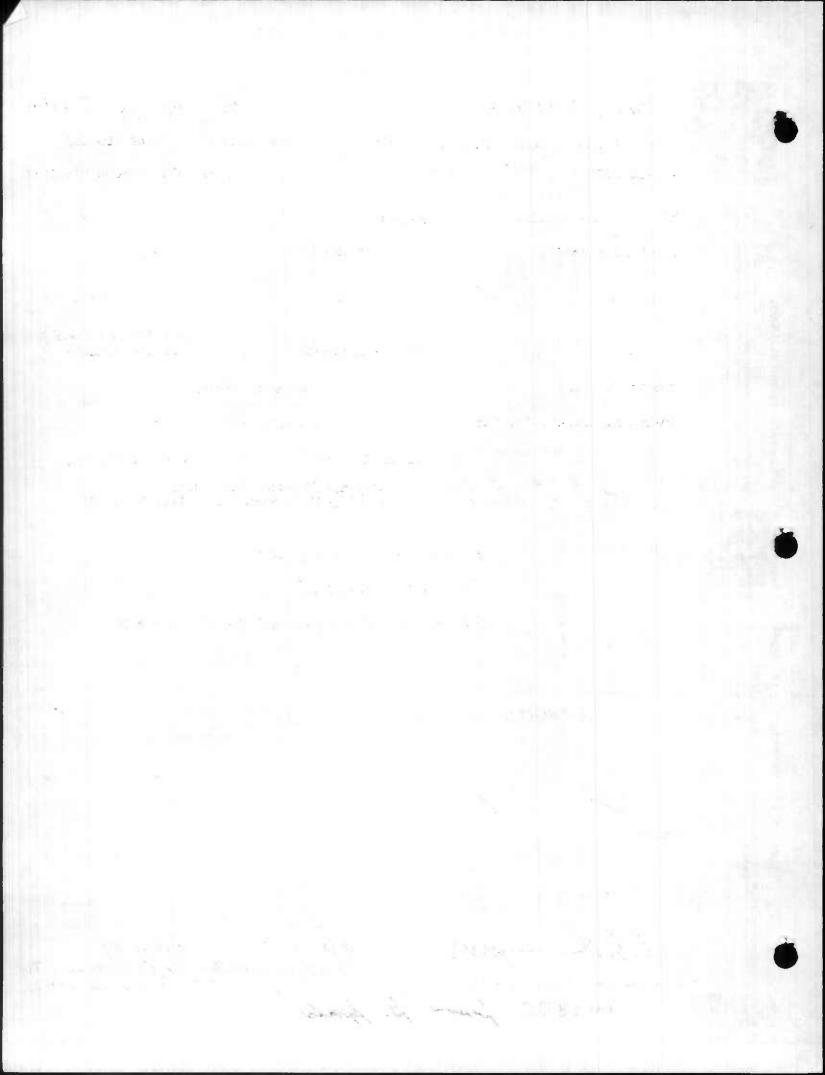
28d. Describe how injury occurred

32. Registrar's Signature

DHMH 16 Rev 6/95

24 hours

To the Vithin 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Donald Colebank MAY 16 7:50 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Commons/Genesis Eldercare Catonsville Baltimore 8. Date of Birth 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 10 M 2□ F Months 234-52-9733 66 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director MD Baltimore Catonsville 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 16 Fusting Avenue 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Heelth and Mental Hygiene. Important: If Itam 27 ia marked other than "natural", or Hes any Injury or other traumatic event, the section 1 Tyes 2 No Korea
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify. 20 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aircraft Builder/ Aircraft Construction Elementary/Secondary (0-12) College (1-4or 5+) Manufacturer Worker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Patrick Colebank Hester White 19a. Informant's Name/Reletionship (Type, Print) 19b. Malting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris J. Turk/Niece 9329 Dunloggin Rd. Ellicott City, MD 21042 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Metro Crematory, Inc. 5/18/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Footiety of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 George E. MacNahh

299 Frederick Rd. Balti

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Onset and Death **Physician** /Medical tmmediate Cause (Final HZPATIC disease or condition resulting in death) Examiner Due to (or es a consequence of) HEPATIC sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 70 3 Probably 4 Unknown py 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 10 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? After Natural 5 Pending investigation Attanding e Hoepital or Attanding 1 24 hours after death. e Funeral Director: After 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier edical (Check only To the F within 2

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier,

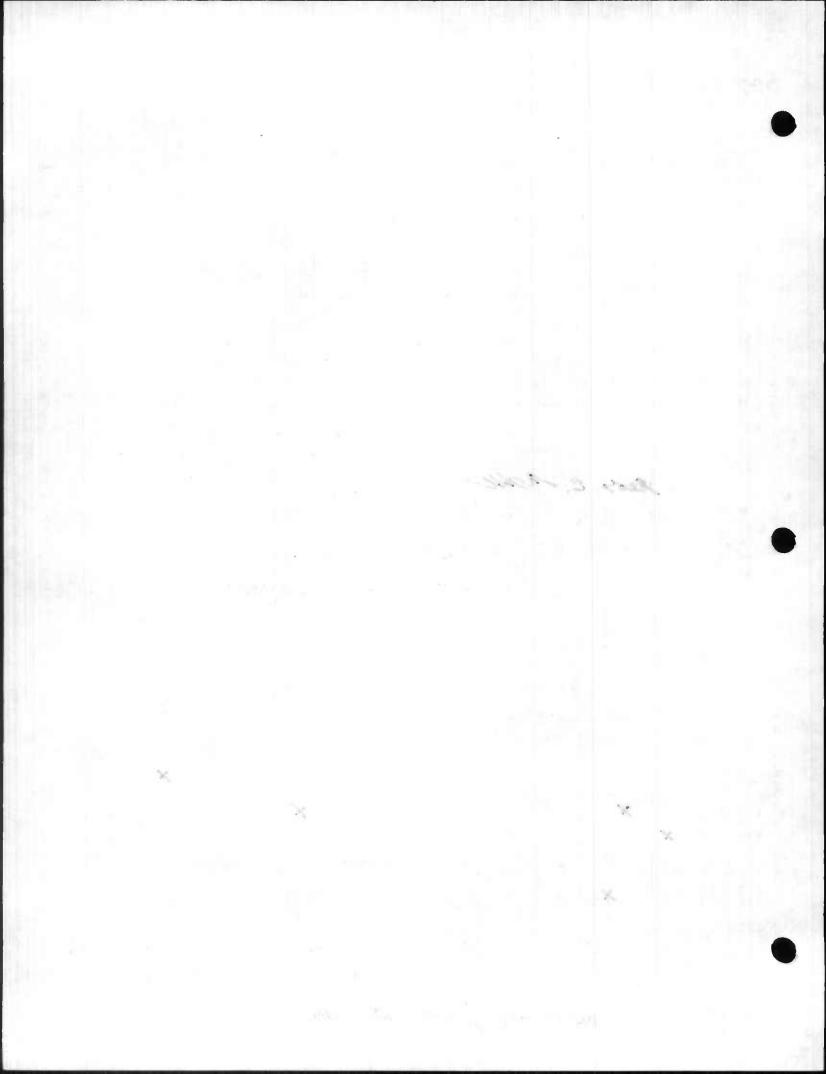
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

TREE RD, SUT SILIC

52360

29d. Date signed (Month, Day, Year)

29c. License number



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#5&10a,b,c,e&F #16b PER F.H. G771 5-28-99 J. ACertificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month **Physician** James William Carroll /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Elkton Cecil Union Hospital | If Under 1 Year | If Under 24 Hrs. | 8, Data of Birth (Month, Day, Year) | March 12 1924 5. Social Sacurity Number 9060 217-18-9660 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1√2 M 2□ F 75 Yrs. Pennsylvania **Director** Usual Rasidance of Decedant 10a. Stata 10b. County HERNANDO 10c. City, Town or Location 10d. Insida City Limits FLORIDA 1 ☐ Yas 2 ☐ No Director Cecil Elkton SPRING HILL 14233 CORNEWALL 10f. Zip Coda 10g. Citizen of What Country? 34609 -21921USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Dalas: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: WWII à Specify: 3
☑ Widowed 4 □ Divorced White Completed Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry PENN/CENTRAL Eiamantary/Secondary (0-12) Collega (1-4or 5+) Railroad Engineer Penn, Railroad 12 17. Father's Name (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maldan Sumama) Margaret J. Dougherty Howard R. Carroll 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 511 Ricketts Mill Rd, Elkton, MD, 21921 Ms. Margaret C. Sybert/Dtr. 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 5-18-99 Parkville, MD. 4 Donation 5 □Othar (Specify) Parkwood Cemetery 21. Signature of Funaral Service Licensi 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 23a. Part1. Entar the diseasa, or combilications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Betwaen Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) Browetto PINEMENDE IF 1 weeks Examiner Due to (or es a consequance of): Examiner 6 weeks ATMAL FISHILLATION Sequantielly list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseese or Injury that initiated events rasulting in daath) Last Dua to (or as a consequance of): PULLUDNAMY FILSNOSIS 6 heonthu Physician/Medical Dua to (or as a consequance of): LYMPHO MA 6 years Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to madical axaminar? Be 26. Placa of Death (Check only one) 1 Inpatient Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation 1 Naturai 1 ☐ Yas 2 ☐ No 2 Accident

P.O. Box 68760. been signed by the should be deteched Division of Vital Records. Attending death. after death To the Hospital o within 24 hours af To the Funeral D completely filled i

the Maryland

death

72 hours efter

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or Items 23a or 28a-f eho traumstic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within: Department of Health and Mental hygiene. Important: If Item 27 is marked other than "reny injury or other traumatic event, the Med

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29b. Signatura and titia of certifiar

Kolando

3 Sulcida 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, ferm, straat, factory, office building, atc. (Specify) 4 T Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner slated. 29e. Certifian (Check only one)

State Registrar

NajErg 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

111 WEST Hish

30. Nama and eddrass of person who completed causa of death (Item 23a) (Type, Print)

(SuitE 214)

29c. Licensa number D07463 29d. Dala signed (Month, Day, Year)

ElKTon, MO 21921

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 930 **Physician** DICHAEL COBB /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NURSING CENTER BALTIMORE If Under 24 Hrs. 8. [7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociel Security Number 6. Sex Funeral 9. Birthplace (Stete or Foreign 1□ M 2□YF Months Days Hours Min. BALTIMORE, MD. 120-80-5010 Yrs. 39 MAY 8, 1960 Director Usual Residence of Decedent 10a. State Hygiene. other than "natural", or itame 23s or 28s-f show rant, the Modical Examination and be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 No Yes 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 MT. HOLLY STREET. 21216 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 X Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: AFRO. AMERICAN À 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be liled witten of Health end Mentel Hygien tant: If itam 27 is marked other theiry or other traumatic evant, ins ARTIST ART Baltimore, Maryland 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surname) Be LEON COBB JOAN ANN WRIGHT 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) IMOGENE 2803 MT. HOLLY STREET, BALTIMORE, MARYLAND 21216 FLOYD AUNT 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Date 20c. Location - City or Town, Stete 1 ☐ Buriai 2 Cremation 3 ☐ Removel from State permit. Page Department of Important: If any injury or METRO CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) 5/14/99 CATONSVILLE, MARYLAND 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL SER, P. A.
1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 21. Signature of Funeral Service Licansee LLOYD M. **ESTEP** 23a. Party Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervat Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final 1cen. disease or condition resulting in deeth) **Examiner** Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last and Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or es e consequenca of): 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ De d Completed 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was en autopsy performed? 1□ Yes 2₺ No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1☐ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending Investigation Attending 1 Neturat efter death. 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, offica building, etc. (Specify) 4 Homicide 6

To the To the To the

a Hospital

State Registrar

29e. Certifier (Check only one)

29b. Signature end title of certifier

Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

6730 HOLABIRD AVE, BALTIMORE, MARYLAND 21222

tertifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Yeer)

DE LE FREE PER DE L'AMBRETON DE PLANTE PROPERTO DE PER DE L'AMBRETON DE THE RIVER STATE OF PRINTERS.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

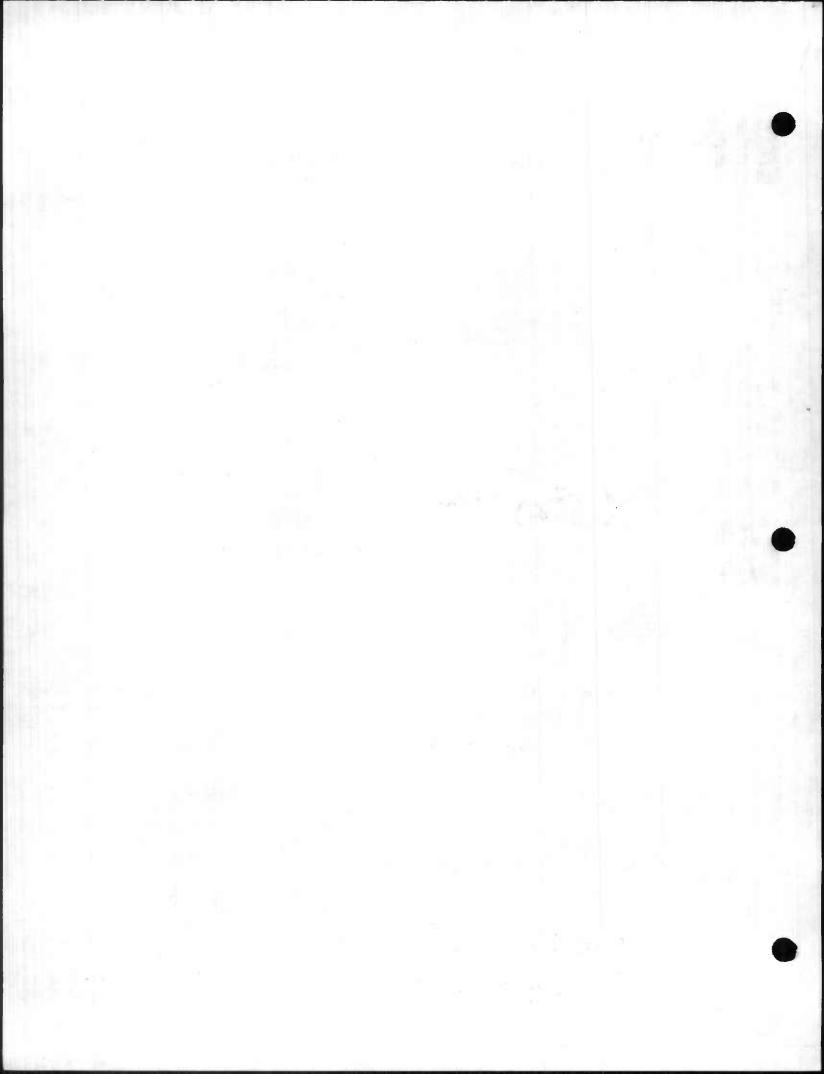
Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month **Physician** 11:55am Lillie H. Craver May 14, 1999 /Medical 4e Facility Neme (If not institution, give street and number) 4h. City. Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Villa Nursing Home Catonsville ${ t Baltimore}$ If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Devs Hours 1 M 2 XF Yrs 229-16-9551 99 Director Maryland Usual Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow the Wedical Examiner must be notified at 10d. Inside City Limits MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 824 Fairway Avenue permit. Pages 1 and 2 should be filled within 72 hours effer death w Department of Health and Mental Hygiene. Important: If Nem 27 Is marked other than "natural", or herns 23s only injury or other traumatic event, the Medical Property and Property. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Amy Florence Oland John Douglas Hett 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 824 Fairway Avenue, Catonsville, MD 21228 Naomi P. Ward (Daughter) 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 → Burial 2 □ Cremetion 3 □ Removel from Stete 5/17/99 Marriottsville, MD Crestlawn Cemeterv 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 21. Signeture of Funerel Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one sauce on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of) 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 thknown bengis be det à 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To this 27. Menne of Death 28e. Dete of Injury (Month, Dev Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending investigation n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Madical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CATONSVILLE, MO FREDGICK 1009, 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State MAY 1 8 1999 Registrar

DHMH 16 Rav 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician	1. Decedent's Nar		ile, Last)				rtificate			2. Date of Do	Day	Year	3. Time of Death
/Medical	Everlena							_		19	1121	999	11:45AM
Examiner	4a Facility Name		. 1	1	ber)			1	4b. City, Town, or Lo Baltim		th 4c. County		
Funeral	5 Social Security	Number Number	6. Sex	01 10	. Age (In <u>vr</u> s	last birthday) If Under 1 \		If Under 24 Hrs.	9 Date of Bi	irth		place (State or Foreign
Director	220-22-6	415	1 🗆 N	2 XX	87	Yrs.	Months D	ays	Hours Min.	(Month, D	14, 1911	ŚĊ	place (State or Foreign intry)
3	Usual Residence	of Decedent 10b. County	v .		10c C	ity, Town or L	ocation						10d. Inside City Limits
rector	Md •		n/a			,	В		timore				1. No 2 No
23a e	10e. Street and Number 12 S. Ellamont Street 10f. Zip Code USA 10g. Critizen of What C											intry?	
b b		rried 2 Mar	Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	NIXIo	J,S. 13.	Was Decedent If Yes, specify		tispantc Origin? (Spe an, Mexicen, Puerto Specify:	ecify Yes or Ne Rican, etc.)	o- 14. Rac Bla Specify	ck, White	ican Indian, , etc. 1ack	
n, ne Medeel Completed	(Spe	15. Deceder	nt's Educat	ion ompleted)		16a. Deci	edent's Usual O	ocup	pation during most of worki d)	ng	16b. Kind of B	usiness/Ir	ndustry
dwo	Elementary/Sec 12th Gra	condary (0-12)		College (1-	for 5+)	_	bo NOT use r		d)		Self-e	molo	ved
ပိ	17. Father's Name		, Last)						18. Mother's Neme	(First, Middle		-	700
To Be	Don Hilliamson												
	19a. Informant's P Harold C	Name/Relations Carr, St	ship <i>(Type</i> ,	Print) SC	n				and Number or Rura ad Severna				ip Code)
		sposition Cremation 5 Other (5		val from Si	taho	cemetery, cre	osition (Name of matory or other ill Cern	r plac		Date	20c. Location - Brookly		
9000	21. Signature of F	uneral Service	Deenses	_	11		2. Name and A		ss of Facility Nut		neral H		
	23a. Part L Enter	the disease, d	r complicat	ions that car	sed the dea				ng, such as cardiac o			PICA •	Approximate
ian	shock, or he	art faiture. List	t only one	cause on ea	th line.							1	Interval Between Onset and Death
ical iner	Immediate Cause disease or conditi	ion		Int	maco	ania	Hei	m	orrha	aP.		1	20 hrsi
	resulting in death)	a		Due to (or as a conse	quence of):	4	orrha	1		1	15.00
nine			b				ensi's	o Y	^			i	13 yrs.
edical Examiner													
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
	resouring in coacin	Last	d										
0	Part II Other sion	ificant condition	one contrib	uting to dee	th but not re-	rulting in the	inderwing cauc	o div	on in Part I	23h Did	I tobacco una co	untribusta i	to the cause of death?
Physician/M										ribute to the cause of death? B Probably 4 Unknown			
by								_				1	
Completed											s an autopsy omed?	8	Vere autopsy findings vailable prior to ompletion of cause f death?
E O										10	Yes 2 No	1	☐ Yes 2☐ No
Be	25. Was case refe examiner?	erred to medica							26. Place of Deeth	(Check only	one)		
	1 ☐ Yes 2 €			pitat: 1 1 Ing		ER/Outpatie		Oth	4 □ Nursing Ho		idence 6 Oth		ity)
2	27. Manne of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occu									280. Describe	now injury occur	rred	
2		2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office 28f. Location (Street and Number of City or Town, Stete)									ber or Ru	ral Route Number,	
of the tuneral	2 ☐ Accident 3 ☐ Suicide	dotom	4 Homicide 286. Place of Injury - At nome, farm, street, fectory, office building, etc. (Specify) 286. Place of Injury - At nome, farm, street, fectory, office City or Town, Stete)										
by the funeral	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only)	determ	ng Physici	en: To the b	est of my kno	owledge, dea	th occurred at the	he tin	me, date end place, opinion, death occurr	and due to the	cause(s) and m	anner as	stated.
iffcation:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physici Examiner	en: To the b	est of my kno	owledge, dea ation and/or in	nvestigation, in	my o	pinion, death occurre	end due to the	, date and place,	and due	to the cause(s)
ledical Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only)	1 Certifyir 2 Medical	ng Physici Examiner	an: To the basend manner	est of my kno is of examina r stated.	owledge, dea ation and/or in	nvestigation, in	my o	me, date end place, opinion, death occurre	end due to the	, date and place, 29d. Date signe	and due	to the cause(s)
orector: After this In by the funeral di striffication: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and	1 Certifyir 2 Medical d title of certifie	ng Physici Examiner	an: To the bis On the bas end manne	est of my kno is of examina ir stated.	tion and/or in	29c. Li	my o	pinion, death occurre	end due to the	, date and place, 29d. Date signe	and due	to the cause(s)
ector: After the by the funeral tiffication:	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	1 Certifyir 2 Medical d title of certifie	ng Physici Examiner er	An: To the bit on the base and manner	est of my knowing of examinar stated.	tion and/or in	29c. Li	my o	ppinion, death occurred by the second occurre	ed at the time	29d. Date signe	and due	to the cause(s)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First Middle Lest) 2. Date of Death 3. Tima of Death 14, 1999 aar Month **Physician** Custodero Deanna F. 6:30 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4405 Mainfield Avenue 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2XF 57 Yes. 218-40-8497 Director 10 1941 Maryland Dec Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show salesi Examiner must be notified at N/A Baltimore City Md. 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 4405 Mainfield Avenue United States death Funeral 12. Was Decedent Ever in U,S Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health end Mentel Hygiene.
Important: if item 27 is marked other than "natural", or item eny injury or other traumatic avent, the Medical Eventual page. Black, White, atc. 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: aitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Kenneth A. Sentz Eunice Kirtz 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank R. Custodero (Husband) 4405 Mainfield Avenue Baltimore, Md. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/18/99 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Militan Knight Jr 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 LEONARD J. RUCK, INC. 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death **Physician** . Mafortalic Carcinoun Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of). 8 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? airon 1 | Yee 2 | No 3 | Probably 4 | Onknown s certificate has been signed by director, page 2 should be detec Records, à 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Type 2 No certificate of Vitai Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medion axaminer? 26. Place of Death (Check only one) Hospilal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) edical Certification: To 1 ☐ Yes To the Hospital or Attending Physiwithin 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral directors. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C-000 an

State Registrar

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31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

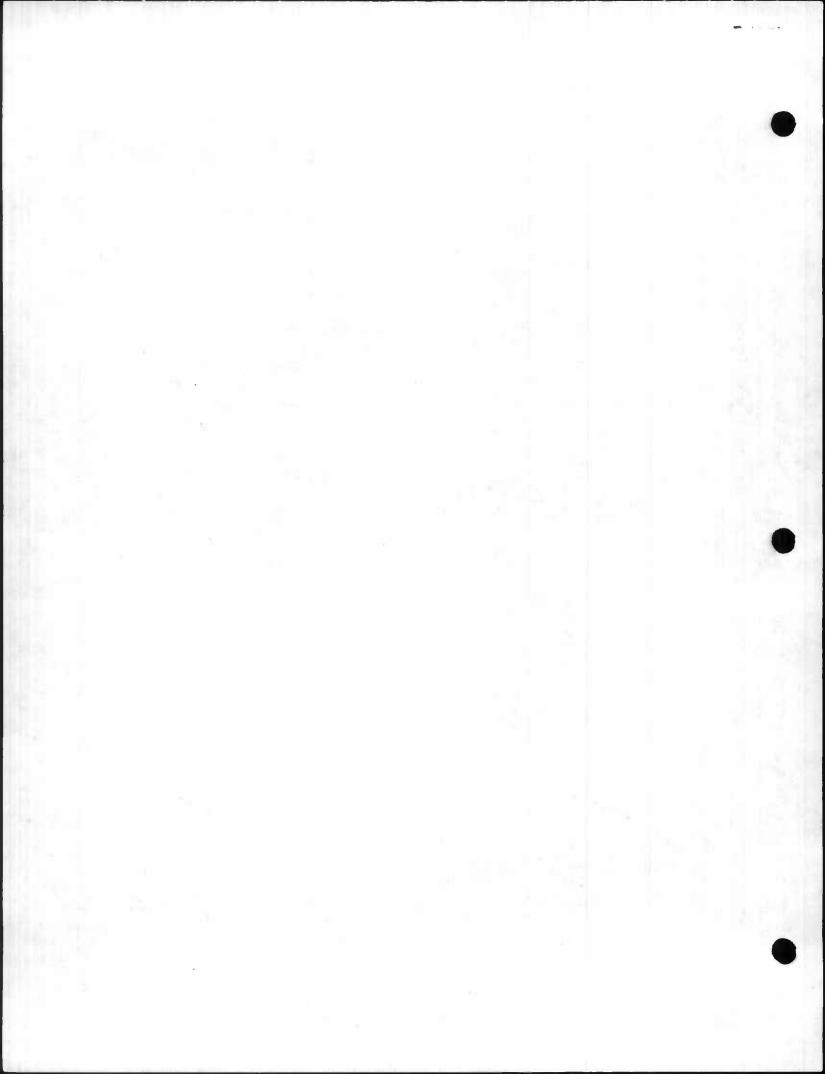
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PATRICIO

32. Registrar's Signature

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IT. Klanyesasp



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yaar C451 C 4b. City, Town, or Location of Deeth 11L DRED 1999 16 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) BALTO HO SPITAL I'll vrs. last birthday) | ff Undar 1 Year | ff Under 24 Hrs. And the Days | Hours | Min. NIA Me MOCIAL UNION 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 85 Yrs. 214-01-7132 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No NIA MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RASPR 21206 4520 AUR U. S.A 12. Was Decedant Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Race - American Indian, Black, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Marriad 2 Married 1 Yes 2 No Specify: Specity: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) It ERBERT 75Ancis 8FARR Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GRAHAM . J. CUSIC 4520 BALTO. 21206 AUR MO RASPE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or othar place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 5/20/99 Cenetery LAKEVIEW CARROLL 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility HARTLEY Miller Funeral Home CHTD. willey Wille 7527 Hasford RD BALTO MD 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In deeth) espiratory Tarluve 10455 Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequença of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner Box 68760, usa P.O.

Records,

Division of Vital

Hospital or Attending Physician:

Aftar

after death.

24 hours

within 2

in by

complately

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28a-f show Examiner must be notified at

Items 23a

as 1 and 2 should be filed within 72 hours aftar death of Health and Mantal Hygiana. I ham 27 is marked other than "natural", or frems 23; other traumatic event, in Madical France.

permit. Paga Department of Important: If any injury or = 0

Physician

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Examine Physician/Medicai by Completed Certification: To

25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 Could not be determined 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Dey Year)

28b. Time of

28c. Injury et Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Naturel

2 Accident

3 Suicide

4 - Homiclde

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and placa, and due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 5/17/99

StrAut 31. Dete filed (Month, Day, Yeer)

3333 32. Registrer's Signature

N. CALVETT ST BALTO, MD

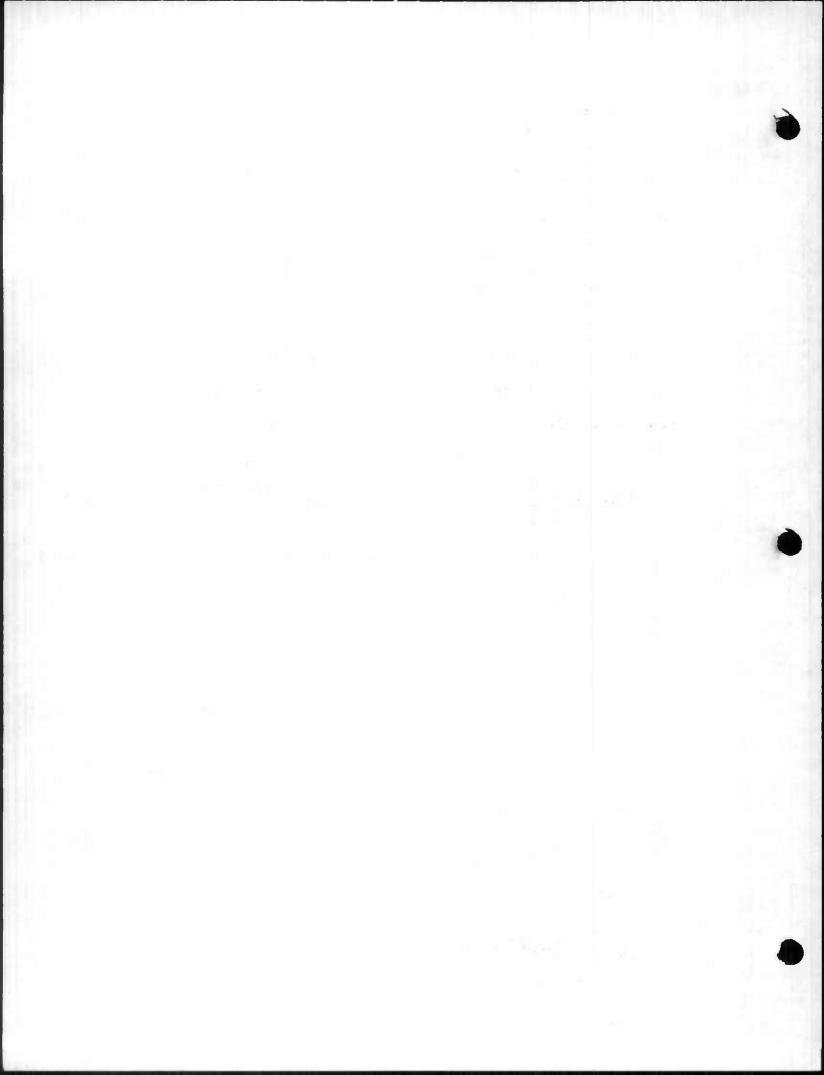
State Registrar

DHMH 16 Rev 6/95

MAY 1 8 1999



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 15863

Certificate of Death

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Physician /Medicai	1		e (First, Middle, Lasi RMA) C	c	ARRO O	2		2. Dete of D Month MAY	eath Dey /6 /	Yeer Aga	3. Time of Death 7 35 AM
Examiner			f not institution, give						or Location of Des	th 4c. County	ol Deeth	
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Funeral Director		5. Social Security N 219-18- Usual Residence of	8778 11	M 200	ge (in yrs.	last birthday) Yrs.	If Under 1 Ye Months Day		- (Alanth F	Pay, Year)	9. Birthp Coun	lace (State or Fore
ž	- 1-	10a. State	10b. County	4	10c. Cit	y, Town or Loca	ation				10	0d. Inside City Lim
in p	5	MD	BAL	TIMORE		P	ARKUILL	0				1 🗆 Yes 2 🖫 1
r items 23a or 28a-f s interment be notified Funeral Director	3	10e. Street end Nun					10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
38.0		7706	VICTORY	AUE				21734	-(1).	5.A.	
ner ner		11. Marital Status	VICTORIA	12. Was Decedent	t Ever in U.	S. 13. W	as Decedent o	of Hispenic Origin? uben, Mexican, Pu	(Specify Yes or N	o- 14. Reco	a - Americ	
by		1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married 4 Divorced	1 Yes 2 H If Yes, Give Yeer or Detes:	No		Yes 2004	-	eno rican, etc.)	Out of the last		ilTe
area steed		(Snec	15. Decedent's Edu	ication		16a. Decede	nt's Usuel Oct	cupation ne during most of w	vorkina	16b. Kind of Bu	siness/Ind	dustry
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or of	1	20e. Method of Disp	osition Cremation 3 🗆 F	Removel from State	C	Plece of Disposi emetery, crema	atory or other p	olace)	Date	20c. Location -		
lury i	-		5 Other (Specify)		YAR	KMOOD	cemet	ery	5/20/99	BALTO	. WE	
any In		21. Signeture of Fu	neral Service Licens	00		22.	Neme end Add	dress of Fecility	Funeral	HOME C	ETH.	
= 0 0		+ Ca	My palle	ller			1527	It a stord	RD. BI	ICD, MD	3-19:	34
		23a. Pert1. Enter the shock, or heer	ne disees or comp it feilure. List only o	lications that cause ne ceuse on each l	ed the deat line.	h. Do not enter	the mode of o	tying, such as card	iec or respiretory	arrest,		Approximete Interval Between
sician	1	Immediate Occas (Flori								1	Onset and Death
edical miner	-	Immediate Ceuse (I disease or condition resulting in deeth)	rinai n	a. Acc	17E	MYO	CARDIN	HE INF	ARC7107	V .	1	IDAY.
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cal cal		Sequentially list cor if any, leading to im cause. Enter Unde Ceuse (Disease or that initieted events	Injury	C	Due to (or	r as e conseque	ance of):					
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d by the atte etached for Physicia	ī	ert II. Other signifi	cant conditions cor	ntributing to death I	but not res	ulting in the und	lerlying cause	given in Part I.	23b. Did	tobacco use cor	ntribute to	the cause of deal
igned by the attered for be detached for by Physicia									10	Yes 20 No	3 ☐ Prot	oably 4 Unknow
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al di	-	1 ☐ Yes 2 ☑ I 27. Menper of Death	NO	Inpati		ER/Outpatient 28b. Time of	3 DOA	4 Li Nursing	1	how Injury occurr		y)
fune fune tion	1	Naturel	5 Pending	28a. Date of Inju (Month, Da	ay Year)	Injury	28c. In V	Vork? ☐ Yes 2 ☐ No	26d. Describe	now injury occurr	90	
y the		2 ☐ Accident 3 ☐ Sulcide	6 ☐ Could not be	28e. Pieca of In	niury - At ho	ome form stree			28f Location	(Street and Numb	er or Rura	I Route Number
To the runstal Director: After this certificate in completaly filled in by the funeral director, page Medical Certification: To Be Com		4 Homicide	determined	building, e	tc. (Specif	y)			City or To	own, State)		
To the Funeral Director: After completaly filled in by the fune completaly filled in by the funeral Medical Certification		29a. Certifier (Check only one)	Certifying Phys 2 Medical Exami	sician: To the best ner: On the basis of end manner si	ol examinat	wledge, death o tion and/or Inve	occurred at the stigation, in m	time, date and ple y oplnion, deeth oc	ce, and due to the curred et the time	cause(s) and ma , date and place,	nner as st and due to	ated. the cause(s)
To the Funeral Dir completaly filled in Medical Cert	100	29b. Signature and	title of certifier					ense number		29d. Dale signed	(Month, i	Day, Year)
		Au	nahm	die			P.	12562	2_	MAY	16,	1999
	-	30. Name and addre	ess of person who co	ompleted cause of	death (Item	23e) (Type. Pi	rint)					
		ANUJ	a ma	H AM	A	6000	SAT	MARIT AS	N Hen	17AL	BAC	7/MORE
State	1	31. Date filed (Mont	h, Day, Year)	32. Regist	rar's Signe							,
Registrar			10V 1 ~ 10	00	ecras	. 4	las	1.1 .				
16 Rev 6/95		1	MAY 1 8 19	33	S. C. C.	ful.	13000	F				

Please Type or Print In Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year 18, Hazel Scaife Detwiler 1999 1:04 AM May 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) St. Agnes Nursing & Rehabilitation Center Ellicott City Howard # Under 1 Year If Under 24 Hrs. Nonths Deys Hours Min. AUG 28, 1 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1 M 2 F 214-62-9524 90 1908 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Howard Columbia 10f. Zip Code 10g. Citizen of Whet Country? 21044 5042 West Durham Road USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Dates: Rece - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Specify: White 1 ☐ Yes 2 X No 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Hazel Jordan Scaife M. McCaslin 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) James Scheltema/Grandson 5042 W. Durham Road Columbia, MD 21044 20e. Method of Disposition
1 ☐ Burial 2 ★Cremetion 3 ☐ Removal from State 20b. Pleca of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete Dete Metro Crematory, Inc. 5/18/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Juneral Service License 22. Name end Address of Fecility regn his Edward A. Gregorchik Cremation Society of MD, 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth hydretion Due to (or es e consequence of): 1cm cn Da Due to (or es e consequenca of):

Physician /Medical Examiner

The law requires that the death certificate be asscuted

Hospital or Attending Physician:

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death.

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r this certificate has the paga

After

within 24 hours after death To the Funeral Director: completaly filled in by the

p

Completed

Be

To

Certification:

edical

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Bings.

Physician

/Medical

Examiner

10e. State

10e. Street and Number

11. Merital Stetus

Directo

Funeral

þ

Completed

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

of filed within 72 hours after all Hygiene.

death with the Maryland

Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest attending physician and for use as the bunal-tran Physician/Medicai

Immediate Cause (Final disease or condition resulting in death)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | LNo 3 | Probably 4 | Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy findings evaileble prior to completion of cause of death?

1 Yes 2 XNo

1 ☐ Yes 2 ☐ No

md 21048

26. Plece of Death (Check only one)

25.	Was case refe	erred to	medical
	1 Yes 2€	No	

Manner of Deeth 5 Pending investigation 1 X Natural 2 Accident

6 Could not be

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

3 Suicide

4 Homlcide

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) and menner stated.

29b. Signeture and title of cartifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

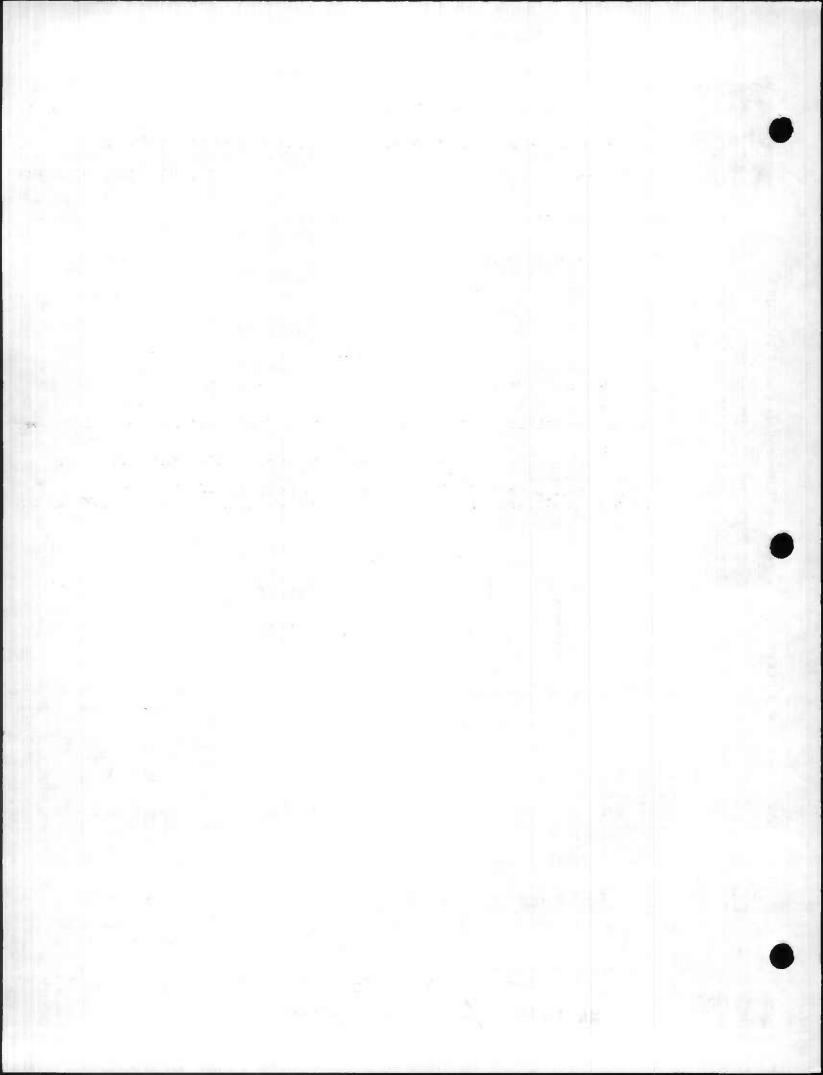
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Sendre Sattin

32. Registrar's Signeture

NRige Rd Ellist

State Registrar



99-2818-510 Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene **JOHN** Certificate of Death DANOWSKI 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** JOHN W. DANOWSKI MAY 16, 1999 04:38 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 SOUTH WASHINGTON STREET BALTIMORE
If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F Months Days Hours Min. Yrs. Director 262-44-1059 66 2/15/33 NEW_JERSEY Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23e or 28e-f show. 1⊠Yes 2□No Directo MD N/A BALTIMORE ž 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 S. WASHINGTON STREET 21231 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: KOREA Shene Was Decedent of Hispanic Origin? (Specify Yee or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or han the Medical Examiner. Bleck, White, etc. hours after 1 Never Merried 2 M Merried Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Mad within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 0 RETAIL SALES LUSKINS permit. Pages 1 and 2 should be fits.
Department of Heatth and Mental Hy important: if them 27 is marked other any Injury or other to 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MELVIN DANOWSKI **JEAN** unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 14 S. WASHINGTON ST. BALTO., MD. MRS. COLLEEN DANOWSKI Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete GREEN MOUNT CEME. 5/17/99 balto., MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility KACZOROWSKI FUNERAL HOME P.A. Lau 2525 FLEET ST. BALTIMORE, 21224 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feilure. Use only one cause on each line. Approximete Intarval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disaasa or condition resulting in deeth) Examiner Dua to (or es e consequence of): Examiner physician and the burial-transit Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or es a consequence of): 080 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 4 signed by it 3 Probably 4 □ Unknown 1 Yes 2 No Records, P 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en autopsy performed? peen has 1 Yee 2 No 1 Yas certificate of Vital or Attending Physician: 25. Wes case referred to medicel axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 1 Inpatiant this 27. Manner of Death 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be detarmined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide vo the Hospital or within 24 hour To the Fr 24 hours after Funeral Di 29a. Certifier Medical 1 Certifying Phyelcian: To the best of my knowledga, death occurred at the time, date end place, and dua to tha cause(s) and mannar as stated. (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and menner steted.

State Registrar

31. Dete filed (Month, Dey, Year) MAY 18 1999

29b. Signature and title of certified

100KE MD 32. Registrar's Signetura

and address of person who completed ceuse of death (Item 23a) (Type, Print)

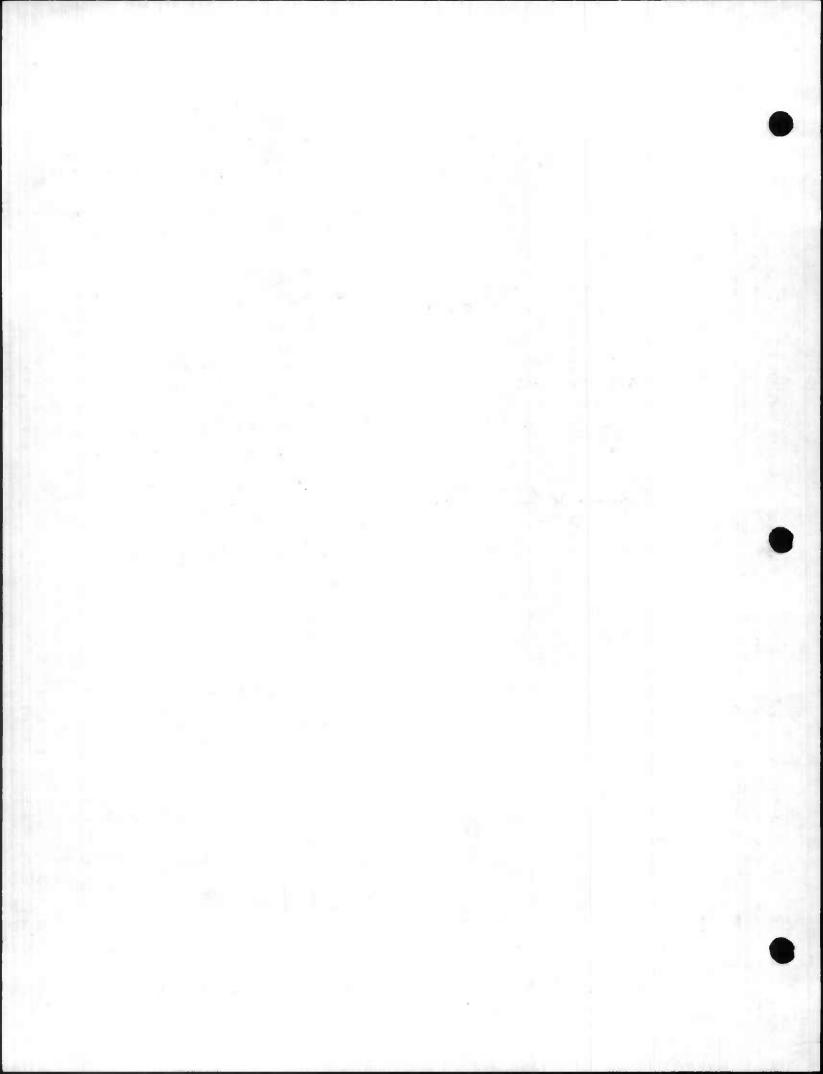
111 Penn Street, Baltimore, Maryland 21201

29c. License number

OCME

MAY 16, 1999

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yaai **Physician** 5 1599 6 Vorothy /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore
If Under 24 Hrs. 8. 0 Medica University BeHIMOR lland 6 Sax 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State of Foreign Country) **Funeral** 1□M 201F Months Deys Hours Min. Director 213-03-9440 Aug. 9, 1918 Baltimore, Md. Usual Rasidance of Decedant death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a Stata 10h County 7 is marked other than "naturel", or items 23s or 28a-f show traumatic event, the Medical Examples must be notified at 1 Yas 2 No Director Md. Baltimore Owings Mills 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21117 12425 Greenspring Ave. U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armad Forcas? 1 ☐ Yas 2 🛣 No If Yas, Giva Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item only injury or other traumatic event, the Medical Evented DAGE. Black, White, atc. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 🕻 No Specify: Specify: þ White 3 ₩ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grede completed) 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry College (1-4or 5+) Elemantary/Secondery (0-12) Owner/Operator Golf Course Golf/Country Club 12 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Mamie C. Ellis George E. Chenowith 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Upperco, Md. 21155
Data 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetary, cremetory or other pleca) Carol Isaac - daughter 20e. Mathod of Disposition Mathod of Disposition

170 Burial 2 Cramation 3 Ramovel from Stata

Dulaney Valley Mem. Gardens 5/20/99 Timonium, Md. 22. Nama and Addrass of Facility 21. Signature of Emperel Service Licansia Eckhardt Funeral Chapel Ende the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.

The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. **Physician** /Medical Immadiata Causa (Final a Hemorrachic 695thic diseasa or condition resulting in deeth) Examiner Examiner physician and the bunal-fransit requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequanca of) 25 980 for Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? detached signed by t 1 | Yes 2 Probably 4 Unknown by 24b. Wara autopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed peed certificate has 1 Tas 2 No 1 ☐ Yas 💥 No Division of Vital Hospital or Attending Physician: director, 25. Was casa rafarrad to madical Be 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No P Inpatiant 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Mannar of Death Data of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Time of 5 Panding invastigation 1 Natural s sftar death. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicida 24 hours Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifia Medical completely (Check only one) To the Vithin 2 29b. Signature and title of certifie 29d. Data signed (Month, Day, Year) 30. Name anti address of person who completed cause of death (Item 23a) (Type, Print) 225.

32. Ragistrar's Signatura

State Registrar

DHMH 16 Ray 6/95

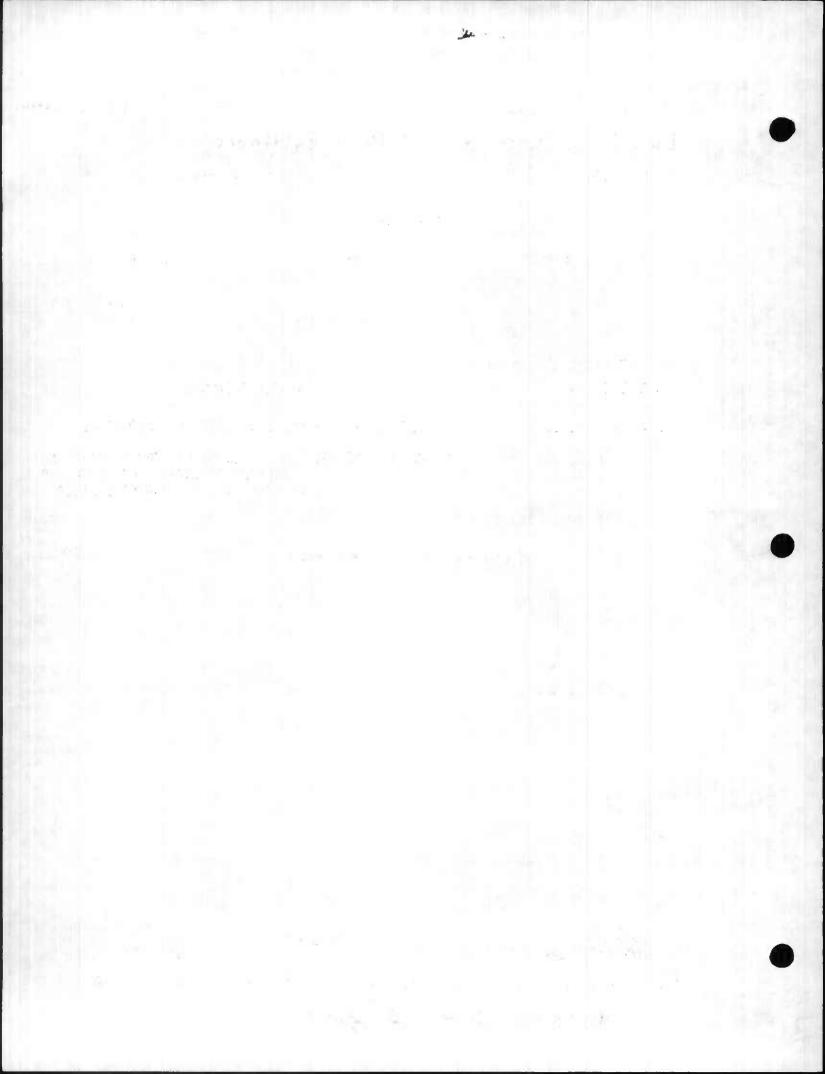
Michse, 31. Date filed (Month, Dey, Yeer) WAY 1 8 1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 99 :57Am e019 DIXON /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs. 8. Dete Center Gensis Eldercare Long Greensty Number Green If Under 1 Year Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys 1□ M 2⊠ F 81 Director 9-1-1917 MD 218-10-5765 Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits the Merylen incora se moderna de de la company de la com Director 1 Yes 2 No MD. BALTIMORE 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? I.S.A. 14. Rece - American Indien, 4303 ADELLE TERRACE Funeral 21229 death 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 72 hours efter 1 Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced BLACK Yeer or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event bace. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ARTHOU DIXON MAGELINE DIXSON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 QUEENSGATE RD. BALTIMORE MARYLAND 21229 BLANCHE FOWLKES 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stele 1 X Buriel 2 Cremetion 3 Removel from State WOODLAWN CEMETERY 5-15-99 BALTIMORE, MARYLAND 4 Donetion 5 Other (Specify) 21. Signeture of Fuperal Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** e. Huntington's un Due to (or es e consequence of) /Medical Immediate Cause (Finel 30 years disease or condition resulting in deeth) Examiner Examiner physiclen and the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. requires that the death certificate be Physician/Medical Due to (or es e consequence of): SBS for use Pert II. Other stanificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? the Division of Vital Records, P.O. datached signed by the 1 Yes 2 No 3 Probably 4 Unknown 2 24e. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to Completed peen completion of cause of deeth? The law has page 1 Yes 2 No 1 Yes 2 No certificata Attending Physicien: director. Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After this funerel 28a. Date of Injury (Month, Dey Year) 27. Menper of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Netural 5 Pending death. 1 Yes 2 No 2 Accident Investigation after death Director: / 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 6 24 hours a Hospital edicai 29e. Certifier 🔯 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner es stated. completaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner stated. (Check only one) within 2 the th 29c. License number 29b. Signature a 29d. Dete signed (Month, Dey, Year) 0 03389 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) St Beltimore Robe & Vissius
31. Date filed (Month, Day, Year) 4300 N. MO harles 32. Registrer's Signeture State

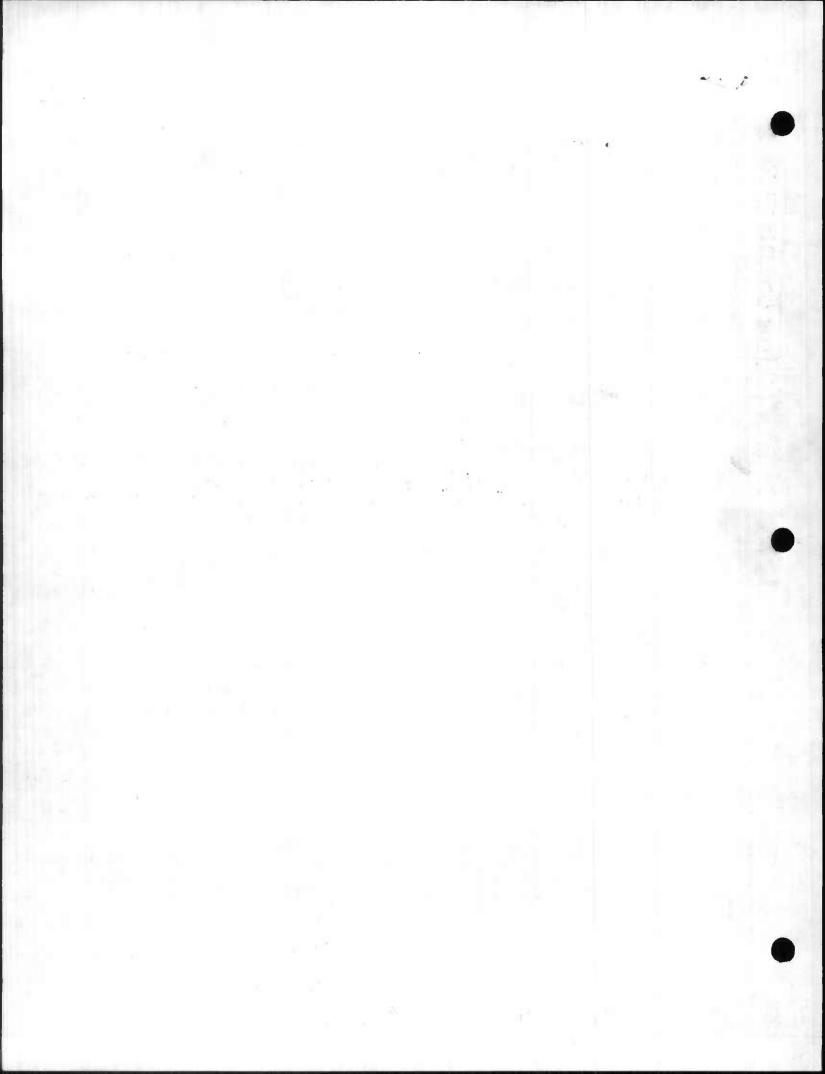
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Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

1. Decedent's Nama (F	(First, Middle, Last	t)		Certifica	ile UI I	Jeani		2. Deta of Dea		19	3. Time of C
HAZEL DUNSTON								Month 05	Day / 4	Year 99	20.2
4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of CHIPCH HOSPITAL BALTIMORE N/A									ity of Deeth		
CHURCH HO 5. Social Security Num			ge (In yrs. last birt	hdev) If Und	ler 1 Year	BAI.			N/A		olece /State or
213-07-32	10	☐ M 25€F		rs. Month		Hours	Min	8. Date of Birth (Month, De) 3 - 15 - 1	Year)	balt	olece (Stete or ntry) O • md
Usuel Residence of De	Pecedent 10b. County		10c. City, Town	or Location							IOd. Inside City
MD	N/A			TIMOR	F2						1 √ Yes
10e. Street and Number			DAL	- 1	Zip Code				10g. Citizen o	f What Cour	ntry?
5706 ADI.E	EIGH AV	E			21:	206				U.S.	Α.
11. Maritel Status 1 ☐ Never Married 3 ※ Widowed 4 ☐		12. Wes Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Detes:	?		V	ispanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ity Yas or No- ican, etc.)		ace - Americ leck, White, hity: BLA	etc.
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Bus									Business/In	dustry	
Elementary/Seconda	lary (0-12)	College (1-4or		life. DO NOT		•		4.4	1101	100113	KDD
3X Widowed 4 E (Specify of Elementary/Seconds 12 17. Father's Neme (Fin	irst, Middle, Last)		1 5	ELF EI	MPLO		's Name ((First, Middle,		ISEMA	KER
HARRY CO	OLE					S	USA	N HOW	ARD		
19e. Informent's Neme				Meiling Addre							
CONSTELLA 20a. Method of Disposi		S (DAUG	20b. Place of	201 El Disposition (A	lame of		, B	Date Date	20c. Location		
1 Donation 5	Cremation 3 DF		cemeter	r, cremetory o	r other pled			-19-99			
21. Signature of Funer			10/	memor:	and Addre	ss of Fecility					
MULL	LEROY O DYETT & SON FUNERAL HO 4600 LIBERTY HIGHTS AVE, BALTO										MD 212
23a. Part1. Enter the c shock, or heert le	disease, or compleilure. List only or	lications thet cause ne cause on each	d the death. Do n line.								Approximete Interval Betw Onset end D
Immediate Cause (Findisease or condition resulting In deeth)	nal	SEPSIS DAY							DAYS		
Due to (or as a consequence of): GANGRENE								1	11000		
									1	WEEKS	
Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or Inju	ediate ing	6	PELIPHERAL VASCULAR DIS					DISEA	E	YEARS	
thet initieted events			Due to (or as a co								
resulting in death) Last	L.	d									
	L,	d	but not resulting in	the underlying	cause giv	en in Pert I.		23b. Did t	obacco usa o	contributs to	o the cause of
Pert II. Other eignificar	ant conditions con					en in Pert I.					o the causs of
Pert II. Other eignificar	ant conditions con	d				en in Pert I.		1 🗆 `		3 ☐ Pro	lere sutopsy file railable prior to completion of ce
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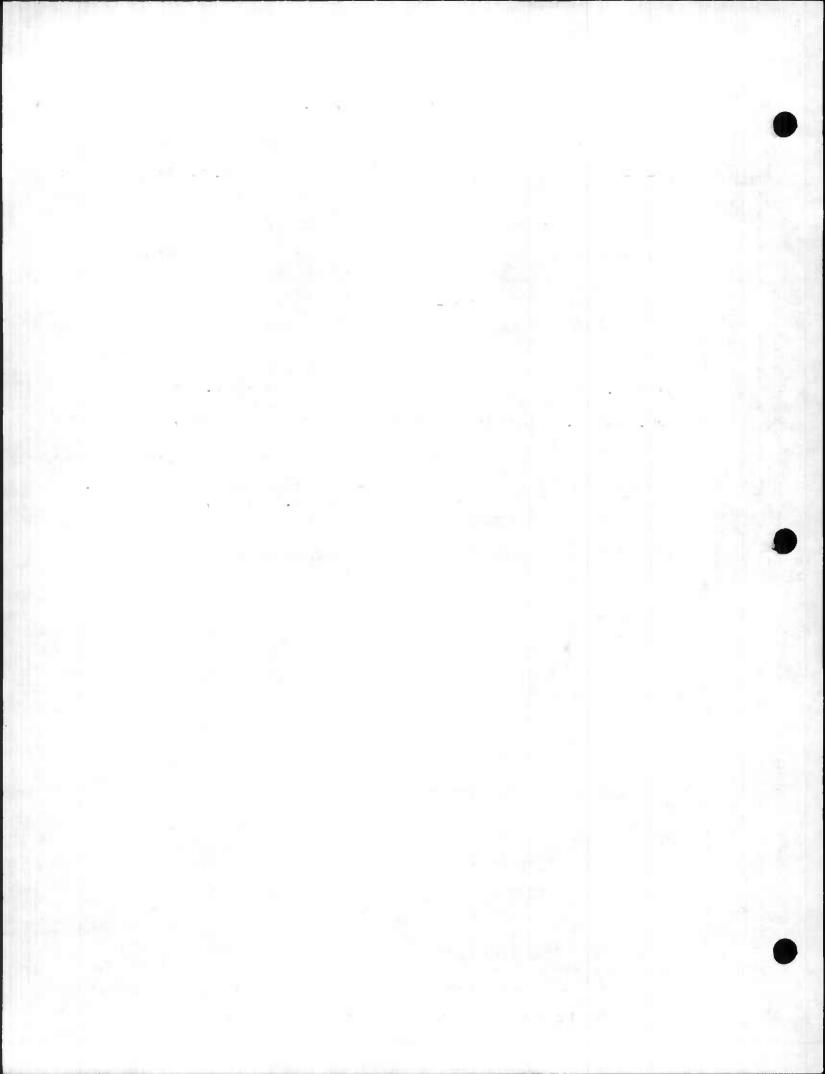


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of Maryland / Department of Health and Mental Hygiene	Q	Q		5	Q	6
Certificate of Death Reg. No.	2	2	1	J	U	U

				Certifica	ate of	Death	R	leg. No.	2 10002			
ian	Decedent's Neme (First, Middle, L	Last) Robert	t Mer]	e Dial	cey,	Sn	2. Date of Dea Month	Dey	Year 3. Time of Death			
1 -	A = 120 NA			e Dici	cey,		May 1.		8:35 A.			
r	4a Facility Name (If not institution, g					4b. City, Town, o	r Location of Death	4c. County	of Daeth			
	7913 Charlesmon				1 3 4 3 4 2 4	Dundalk			timore			
	5. Social Security Number 6. 215 - 30 - 4890 Usuel Residence of Decedent	1⊠ M 2□ F	e (In yrs. last bii 64	Yrs. If Und	ter 1 Yea s Days			, Year)	9. Birthplece (State or Fore Country) Maryland			
+	10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Lim			
									1 ☐ Yes 20			
Maryland Baltimore Dundalk 10e. Street end Number 10f. Zip Code								IO- Chi/ N	After County Co			
	7913 Charlesmo	Og. Citizen of V Unite	d States									
ſ	11. Merital Stetus	13. Wes Dec	edent of	Hispanic Origin? (Specify Yes or No- irto Rican, etc.)		e - American Indien, ck, White, etc.					
	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	If Yas Give	No 1957-59 1□ Yes 2⊠ No Specify:						White			
-	15. Decedent's I	16a						usiness/Industry				
r	Elementary/Secondary (0-12)	5+)	· ·									
Ļ	12 Years			Exped.	iter				Industry			
١	17. Father's Neme (First, Middle, Las	st)				18. Mother's No	eme (First, Middle,	Maiden Sumem	10)			
	Merle F. Dicke	ey				Marg	garet G.	Jackson				
	19a. Informant's Name/Reletionship	(Type, Print)					Rural Route Numbe					
	Mrs. Rosie J.	Dickey/Wif	e '	7913 Ch	arle	smont Roa	ad Dunda	lk, Mar	yland 21222			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	☐Removel from State		f Disposition (A ry, cremetory o				20c. Location -	City or Town, Stete			
L	4 □ Donation 5 □ Other (Spec	cify)	Oak 1	Lawn Ce	mete	ry 5/1	7/1999	Balti	more, Marylar			
	21. Signature of Funeral Service Lice	ensee	l Home of Dundalk,		· ·							
	Immediate Cause (Finel disease or condition resulting in death)	· BULL	Roscor	wron	CP	מיטו הת	Sunt	DUSTOS	Onset end Death			
Examiner	Tooling in doubly		Due to (or es e	consequenca o	of):							
The same	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of):								1			
resulting in death) Last												
-			1									
	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contribute to the cause of death				
							- 10Y	′ee 2□ No	3 Probably 4 Swinkn			
combined by							24a. Wes	en eutopsy	24b. Were autopsy finding eveilable prior to			
							POSS		completion of cause of death?			
							100	11.4				
	11						no v		1 Hes 2□ No			
	25. Wes case referred to medical examiner?	Hospitel:			10	26. Place of D	eath (Check only or	ne)				
2	1 Ness 2 No	1 LJ Inpate			DUA	4 LI Nursing	Home \$CXPesid					
Certification	27. Manner of Death 1 ☑ Netural 5 ☐ Pending	28a. Dete of Inju (Month, Da	y Year) 28b.	Time of Injury M	28c. Inj W		28d. Describe h	ow injury occur	red			
	2 ☐ Accident investigation		Yes 2 No	28f. Location (Street and Number or Rural Route Number,								
	3 Suicide 6 Could not determine	28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)										
	dotormino	building, an	29a. Certifier (Check only (Ch									
	4 Homicide determine 29a. Certifier 1 Certifying P	Physician: To the best of aminer: On the besis of	examinetion en	o, deeth occurre d/or investigetion	ed at the on, in my	time, date end place opinion, death occ	ce, and due to the courred et the time, o	ause(s) end me late end pleca,	enner es steted. end due to the ceuse(s)			
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	29a. Certifier (Check only one) 29b. Signature and title of certifier	Physician: To the best of aminer: On the besis of	examination and attention attention and attention atte	d/or investigetion	on, in my 9c. Licer	opinion, death oc	curred et the time, o	late end pleca,	end due to the ceuse(s) d (Month, Day, Year)			



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yea Jon Henry David May 1999 6:45 am 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7900 Benesch Circle, Apt. 833 Glen Burnie Anne Arundel If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 1 XM 2 F 34 212-82-7965 Yrs 12,1964 South Dakota Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2 No Glen Burnie 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 7900 Benesch Circle, Apt. 833 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2000 14. Race - American Indian. Black, Whita, etc. 1 Never Merried 2 Married 1 Yes XNo Specify: White Specify: 3 ☐ Widowed 4 🕅 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sign Hanger Champion Realty 17, Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) David Kenneth David Gail Eilynn Erickson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informant's Name/Relationship (Type, Print) Gail David (Mother) 842 Mago Vista Road, Arnold, MD 21012 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Cemetery 05/14 21. Signeture of Funeral Service Licental 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, null MD 21401 chel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilura. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

the death certificate be executed

The law requires that Records,

this

After

24 hours after death.

To the To To the F

Hospital

filled in

Medical

P.O. Box 68760

Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

by

Completed

Be

the Marylend

deeth

permit. Peges 1 and 2 should be filed within 72 hours effect. Department of Health and Meniel Hygiene. Important: If Hem 27 is marked other than "natural"——any injury or other traumatic average.

Examiner physicien and the burial-transit USe for signed by the a d be detached f Certification: To

Physician/Medical Completed by Be

25. Wes casa reterred to medical examiner? 1 Yes 2 No

29a. Certifier

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

(Check only one)

5 Pending investigation 6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Hesidence 8 Other (Specify) 28d. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b.	Sig	neture and	title	of	certifier
		1			

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Neme and address of person ath (Item 23a) (Type, Print) Who completed cause of d

MAY 1 8 1999 31. Date filed (Month

32. Registrar's Signature

State Registrar

in a series of the series of the series

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** May 15, 4:07 p.m. Katherine M. Dunlap 1999 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Baltimore Co. Towson Gilchrist Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1□M 20 F Months Days Hours Yrs 212-01-0229 88 09-24-1910 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Parkville Director Baltimore Co. Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Examiner must be r 21234 Apt. # 2321 8810 Walther Blvd. United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 'natural', or 1□ Yes 2X No Specify: Specify: þ White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Heating & Elementery/Secondery (0-12) College (1-4or 5+) Air Conditioning Fuel 8th Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Mental Mental is marked Catherine M.C. Hille John William Marguardt should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Nem 27 is n Mr. J. Robert Dunlap 144 North Shore Drive Mooresville, NC (son) 20b. Piace of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/99 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road Baltimore, MD LEONARD J. RUCK, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Squamors cell concer of Examiner Due to (or as e consequence of) Physician/Medical Examiner ettending physician end for use es the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) UNIAP, HATHERINE Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): ed by the e 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy pege 2 should Completed certificate has I 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: After t Attending 5 Pending Investigation 1 Naturai 1 □ Yes 2 □ No deeth. or Attend efter deeth Director: 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signatura and litie offcertifier

State Registrar

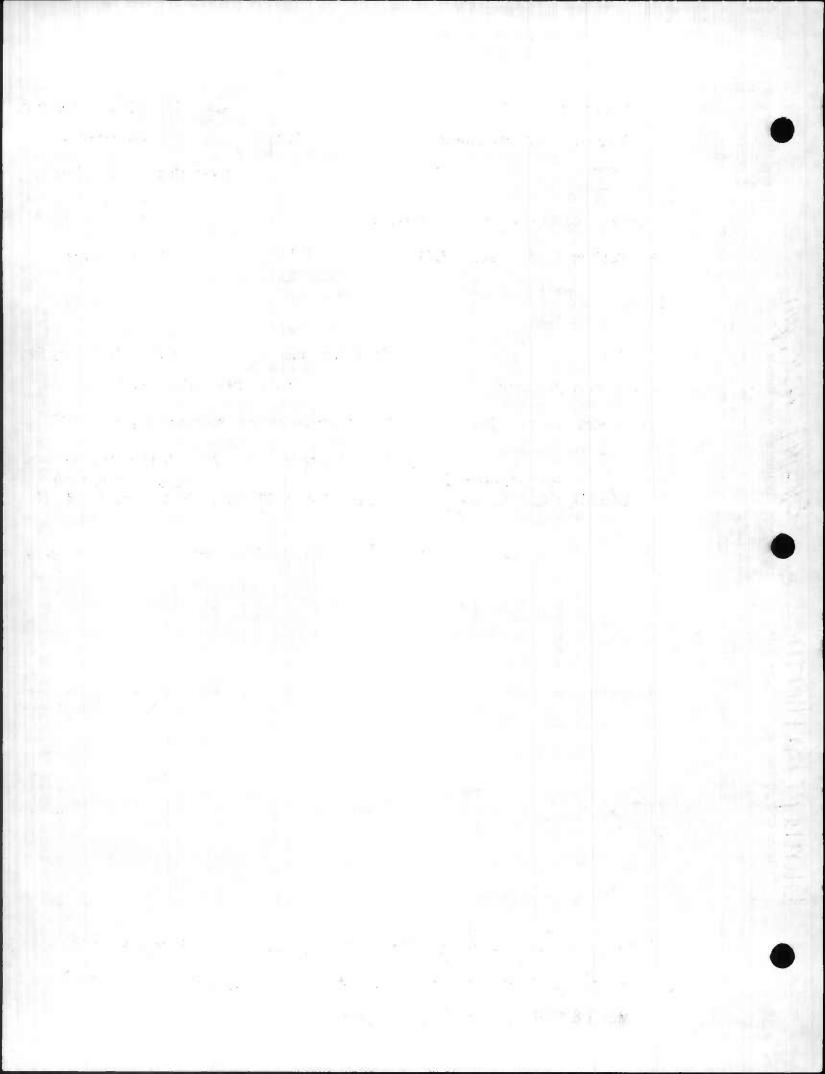
MAY 1 8 1999

31. Date filed (Month, Dey, Year)

le.

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signature G. Sparks



Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1 Decedent's Name (First, Middle, Last) MAY 16 1999 0117 PM JOSEPH PAUL EAST, SR. 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) BALTIMORE ST. AGNES HOSPITAL 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Deys Hours Yrs. 217-38-5649 57 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩ Yes 2 No BALTIMORE N/A MARYLAND 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21223 2422 WILKENS AVENUE 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 X Merried 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FROZEN FOOD COMPANY WAREHOUSEMAN 6TH GRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) EVELYN ENSEY LOUIS EAST 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2422 WILKENS AVENUE - BALTIMORE, MARYLAND 21223 MARY E. EAST (WIFE) 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) Mausoleum 5/20/99 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 22. Name end Address of Fecility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. Let only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Ceuse (Final disease or condition resulting In death) MAASSIVE HEMOPTYSIS 20 MINUTES Due to (or es e consequence of): CANCER -MIETH STATTE LUNG Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown EMPHY SEMA 24b. Were eutopsy findings aveilable prior to 24e. Was an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 27 Menner of Death 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1. Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

P.O. Box 68760. of Vital Records, **Physician**

/Medical

Examiner

Funeral

Director

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Hygiene.

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permit. Pages 1 end 2: Department of Health at Important: If Item 27 is any Injury or other trai-

Physician

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altimore, Maryland 21215-0020

Registrar

31. Dete 11 9 10 11 19 1999

29b. Signeture and title of cegilier

4 Homicide

(Check only one)

29e. Certifier

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) LAMBRUS CUMTIS

32. Registrer's Signeture

AGNES HUSPITAL

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

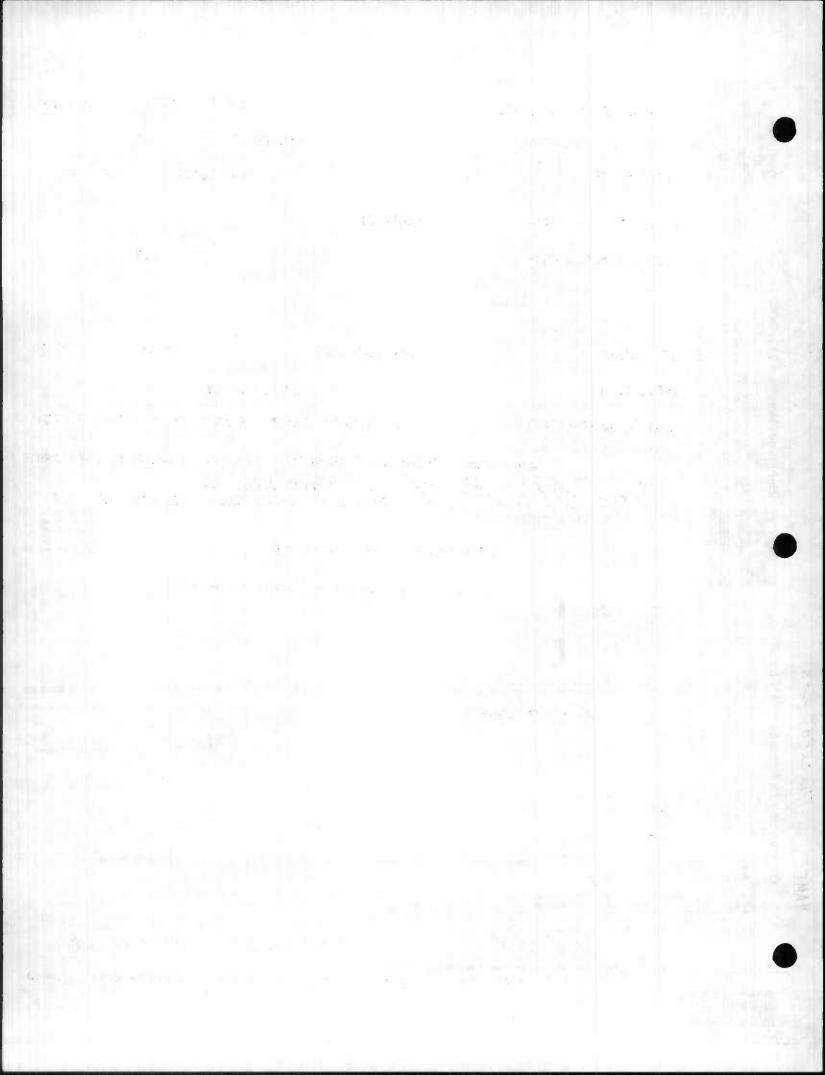
29c. License number

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29d. Date signed (Month, Dey, Year)

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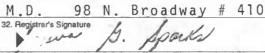
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neral ector		Social Security Number 6. 212-36-2228 Usual Residence of Decedent	Sex 1□ M 282XF	7. Age (In yrs 60		hday) If Un Month	hs Days		. (Month, D	rth ay, Year) 16,1938	Birthplace (State or Forei Country) Maryland	
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Dire										10g. Citizen of W	Marie Control	
ara l		41 Shipping Place Apt. B9 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent						21222	04. V N		States - Amarican Indian.	
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BeC		7. Father's Name (First, Middle, Las	st)					18. Mother's Na	me (First, Middle	, Maiden Sumam	ө)	
		John Rushford						1	Marqueri	te E. Bu	ck	
item 27 le other trau	1	19a. Informant's Name/Relationship Robert E. Woolse				Mailing Addr		at and Number or F	Diego,	10.	_	
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State Registrar

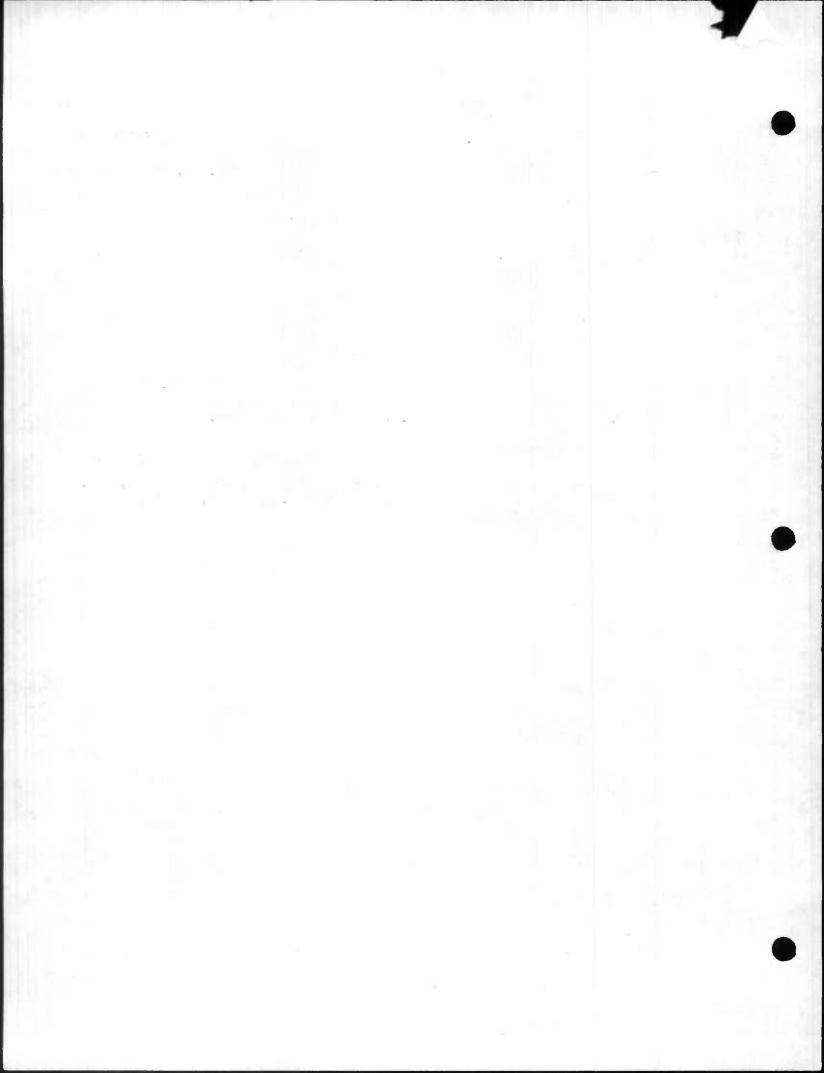
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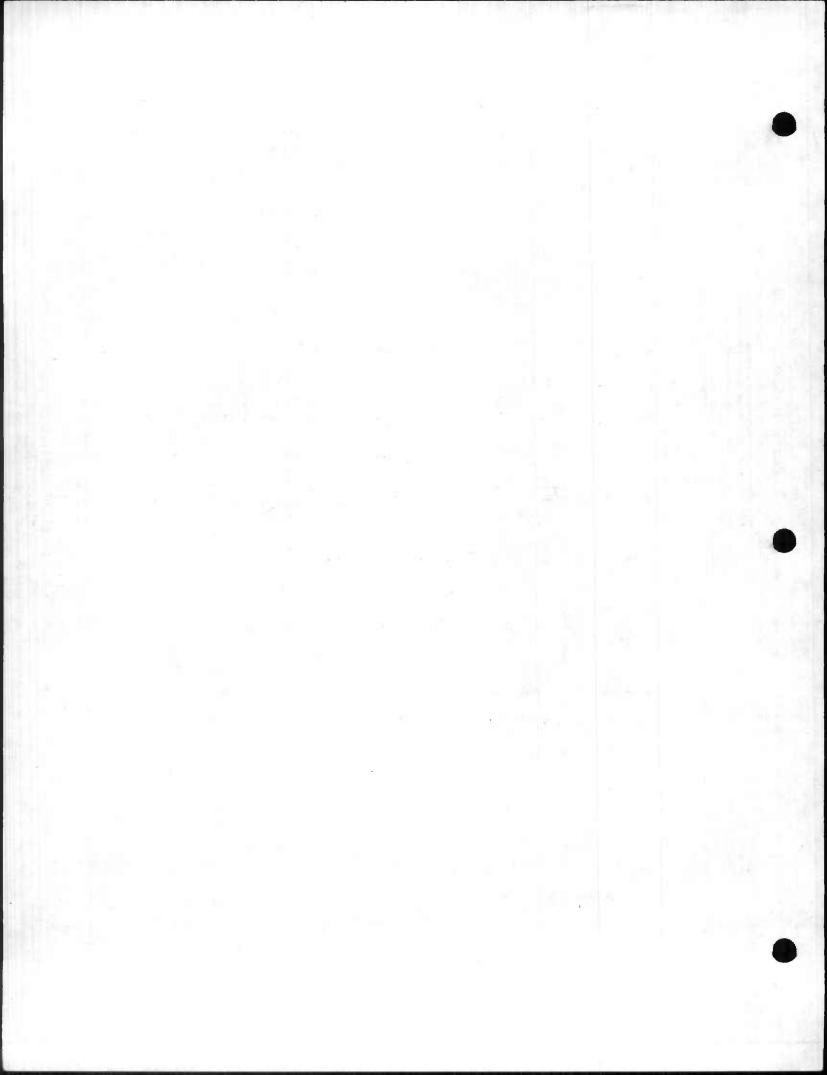


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State of Maryland / Department of Health and Mental Hygiene

		and the second		(Certificate of	Death		Reg. No.	3	5874
	Physician	1. Decedent's Name (First, Middle, Las ROBERT L.					2. Dala of De	Day ,	0880	3. Time of Death
	/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Town, or	MA4 Location of Deat			1012
		UNION MEMORI			M Haday 4 Van	BALTIN			N/A	
	Funeral Director	5. Social Security Number 225–18–6027 Susual Residence of Decedent	7. Age (in 7.	yrs. last birth	Months Days		(Month, De	rth sy, Year) I-1919	Count	aca (State or Foreign ry) GINIA
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		10e. Street and Number 537 OAKLAND	AVENUE		101. Zip Code 2	10g. Citizen of What Country? U.S.A.				
020	wars after death value and the free ment by Funeral	11. Meritel Status 1 Never Merried XX Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent of If Yes, specify Cult 1 Yes XXX No.		Specify Yas or No to Rican, etc.)	Specify	ce - America ck, White, e	
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Division	tal or Attanding P rs after death. al Director: After to a lin by the funer Certification:	1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined	286. Place of injury -	At home, 1em	M 1[Yes 2 No	281. Location	(Street and Numl	per or Rura	Route Number,
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	within 24 hours within 24 hours To the Funeral I completely filled	(Check only 2 Medical Exam	iner: On the basis of axar and mannar stated.	ninetion end/	or investigation, in my	opinion, deeth occu	urred et the time,	, dete end plece,	and due to	the cause(s)
	with I to the common M	29b. Signeture and titla of certifier	on from fe	ugigh	29c. Licer	438946	.N53	HAY 14	d (Month, E	199
		30. Nama and address of person who of JOSEPH A.	Besso MI	u	ype, Print) NLON MEI	MORIHL	HOSPITA			
	State Registrar	MAY 1 8 1999	32. Registrar's S	4						
DHI	MH 16 Rev 6/95			19	orth					

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month May 14, 1999 Mary Virginia Gilbert 1:10 PM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Glen Meadows Health Care Center Glen Arm Baltimore If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 1 M 2 XF 214-07-8313 Yes FEB 6, 1917 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 USA 12. Was Decadant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. 3 XWidowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 Coilege (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alexander Jones Edith Dunnock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Gilbert / son 820 Arnold Road Westminster, MD 21157 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 5/17/99 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility MacNabb Funeral Home, P.A. George E. MacNabb 301 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, laading to immediate ceusa. Enter Underlying Causa (Disaase or injury that initiated avants resulting in death) Last due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the ceuse of deeth? 1 ☐ Yee 20 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a, Was an autopsy periormed? 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Naturai 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not ba determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

physician and the burial-transit The law requires that the death certificate be executed signed by the his certificate has b or Attending Physician: this spital c.
4 hours after oc.

-vel Director: Air.

-in by the fur To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in b.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Funeral

Director

Pagas 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hygiene. And the merked other than "patural" or items 23s or 28s-f show thit if them 27 is merked other than "patural" or items 23s or 28s-f show any or other traumatic event, its Medical Examiner main be notified at any or other traumatic event, its Medical Examiner main be notified at

Physician /Medical

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Certification: To

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Division of Vital Records, P.O. Box 68760,

State Registrar

29a. Cartifier (Check only one)

29b. Signature and title of certifier

30. Nama and addrass of person who completed cause of death of them 23a) (Type, Print) W. A-Riley GBMC 676(N. 6-BMCC

mo

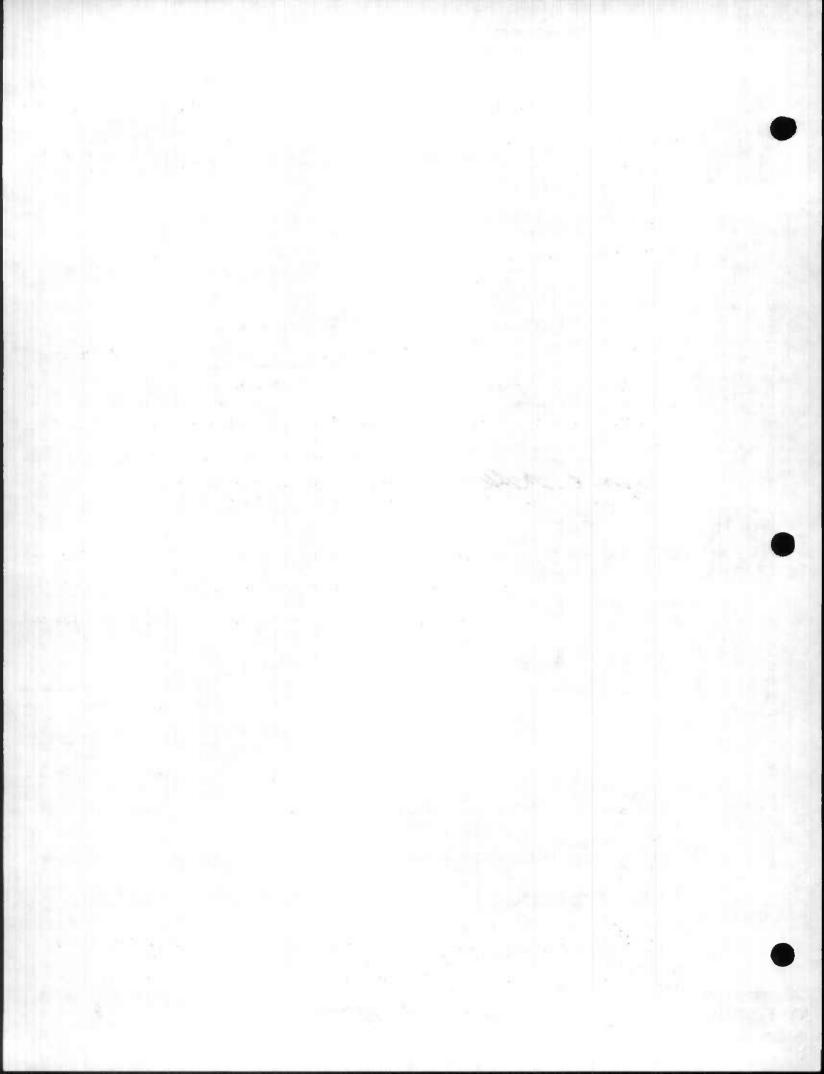
29c. License number

1 Cartifying Phyeician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date aigned (Month, Day, Year)

Charles St. Balto and ZIZOX 6701 N.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month MARGARET GOLDER EDNA 18,1999 MAY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GRANTLEY STREET If Under 24 Hrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Months Days 219-16-8203 1 M 2 F 32 Yrs NOV. Q, 1916 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA 1 Yes 2 □ No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? GRANITLEY ().S.A STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Merital Status Black, White, etc. ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) KNIGHT WADE EMMA SNOWDEN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6705 LONGHILL ROAD, BALTIMORE, MD &1207 LORRAIN HUNT (DAUGHTER) 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State ARBUTUS MEMORIAL PARKO5-17-99 ARBUTUS, MARYLAND 5 Other (Specify) 21. Signatu Funeral Service Deersee 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Mannar of D 28b. Time of 28c. Injury at Work? Natura 2 No 2 Accident 1 Yes

and physiclan Box 68760. Physician/Medical 980 Division of Vital Records, P.O. Completed or Attending Physicien: Be Certification: To this death. after death Director: 24 hours after Funeral Dire letely filled in b

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

or items 23s or

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Hygiene.

Department of Health and Mental important: If Item 27 is marked or any injury or other traumatic eve Pages 1 and 2 should be

Physician /Medical

Examiner

Examiner

by

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Baltimore, Maryland 21215-0020

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Funeral

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6 Could not be

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signeture end title of certif

3 Suicide

4 Homicide

29c. License number

29d. Date signed (Month, Dev. Year)

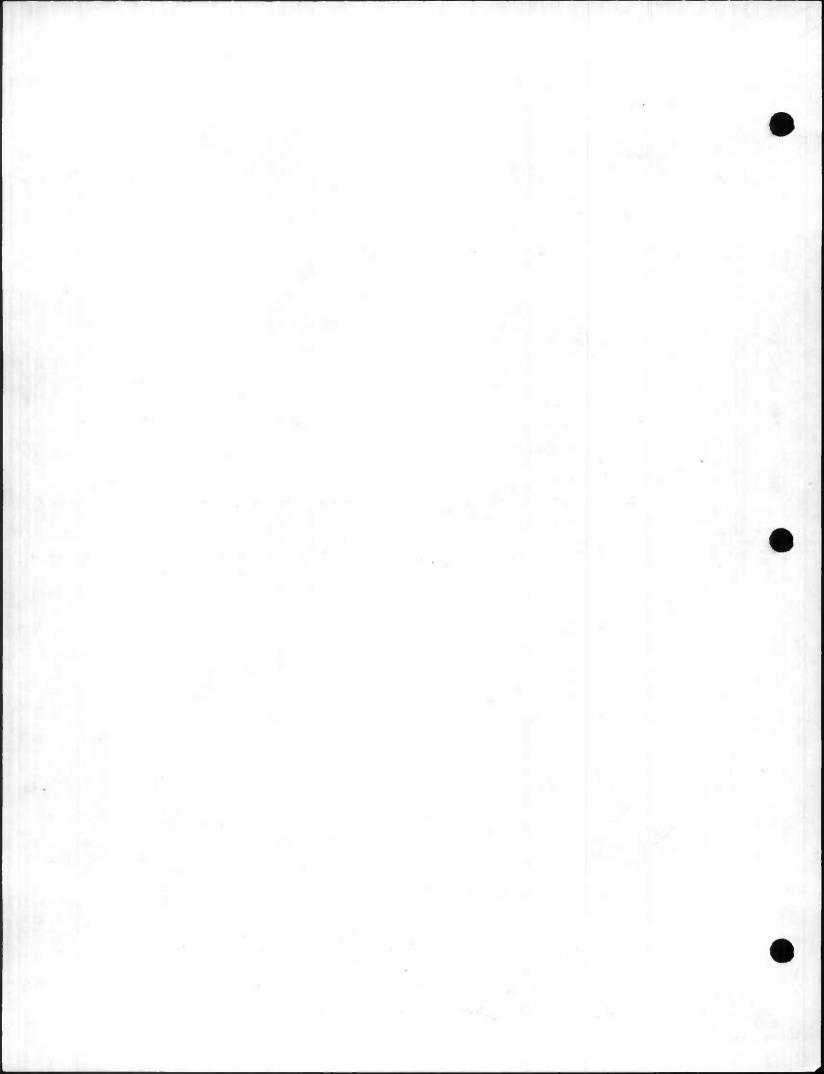
30. Name and address of person

State Registrar

DHMH 16 Ray 6/95

Hospital

To the P



1 □ M 2√2 F

Reg. No. 2. Dete of Death 3. Time of Death

Month 999 3090 na 6 4b. City, Town, or Location of Death time we If Undar 24 Hrs. 8. Data of Birth Month, Day, Yaar) DEC 12, 1903 Birthplece (State or Foreign
 Country) Days Hours Min Virginia

212-32-8588 Usuel Residence of Dacedant

Funeral

Director

Director

Funeral

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Completed

permit. Peges 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Examples must be notified at once.

Physician /Medical

Examiner

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After

Director: /

within 24 hours after To the Funeral Director Completely filled in

death.

director,

The law requires that the deeth certificate be executed

Examine

Physician/Medical

by

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

10b. County 10e. Stete MD Baltimore 10c. City. Town or Location Essex

Yrs.

(In yrs. lest birthday)

95

10d. fnside City Limita

10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21221 1 Eastern Blvd.

11. Meritei Status 1 □ Never Married 2 □ Married

12. Was Dacedant Ever in U,S. Armed Forces? 1 □ Yas 2 ☑No tf Yas, Give Yaar or Dates:

 Was Dacadant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yas 2 No Specify:

14. Race - Amarican Indien, Bleck, Whita, atc White Specify

Own Home

1 Yes 2 No

15. Decedant's Education (Specify only highest grada complated) Elementery/Secondary (0-12) College (1-4or 5+) 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT use retired) Homemaker

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

16b. Kind of Business/Industry

USA

17. Father's Name (First, Middle, Last)

3 XWidowad 4 ☐ Divorced

Unk. Young 18. Mother's Nama (First, Middla, Meiden Sumema) Ellen

19e. Informant's Name/Relationship (Type, Print) Helen L. Bonnet/daughter 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 3017 Sixth Ave. Carney, MD 21234

20a. Mathod of Disposition

20b. Place of Disposition (Nema of cematary, crametory or other place) Cedar Hill Cemetery

20c. Location - City or Town, Stata 05/17/99Brooklyn Park, MD

Unk.

4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licansee
George E. MacNabb

1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State

22. Nama and Address of Facility MacNabb Funeral Home

301 Frederick Rd. Baltimore, 21228 MD

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Batween Onsat and Deeth

Immediata Causa (Final disaasa or condition rasulting in death)

ardiac

Sequentially list conditions, if any, leading to immediata ceuse. Enter Undarlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last

Dua to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other signiffcant conditions contributing to deeth but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy

24b. Wara autopsy findings aveilabla prior to complation of causa of death?

1□ Yes 2 No 26. Placa of Daath (Check only ona)

1 ☐ Yes 2 ☐ No

25. Was casa rafarred to medical axaminar? 1 Yas 2 No

27. Mannar of Death

1 Natural

2 Accident

4 ☐ Homicida

3 ☐ Sulcida

28a. Data of Injury (Month, Day Year) 5 Pending

invastigation

6 Could not be datarmined

1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Tima of 28c. Injury et Work?

Other: 4 Nursing Home 5 Rasidenca 6 Othar (Specify)

28d. Dascribe how injury occurred 1 ☐ Yas 2 ☐ No

28e. Pleca of Injury - At home, tarm, straat, factory, offica building, atc. (Specify)

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a, Cartifiar

** Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar stated.

29b. Signature and titla of cartifian

29c. Licansa number

29d. Data signad (Month, Day, Yaer)

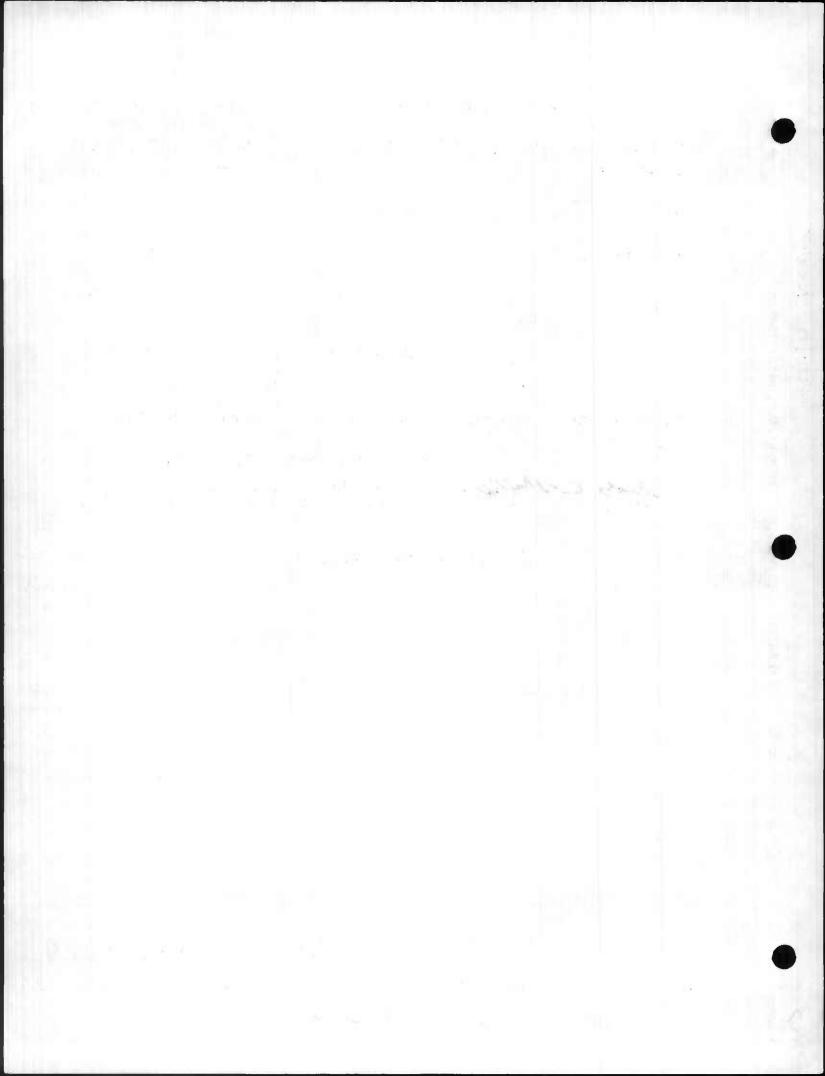
30. Nama and addrass of person who complated causa of daeth (Item 23e) (Type, Print)

9000 Franklin Square Drive Baltimore M D.21237 Sireesh Tripuraneni 32. Registrar's Signatura

Quel

Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospital 130

> State Registrar



P.O. Box 68760, Records, Division of Vital

certificate be executed signed by the attending physician end is be deteched for use as the buriel-trar The law requires that the death peed certificate hes page 2 Physician: funeral director. eral Director: After this filled in by the funeral di Hospital or Attending 14 hours after death. within 24 hours a
To the Funeral C

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

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permit. Peges 1 end 2 should be file.
Department of Health and Mentel Hygh
Important: if tiem 27 is marked
any injury or other 12.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification:

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(Check only one)

29b. Signature and title

30. Name and address.

MARTIN

Maryland 21215-0020

State

Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

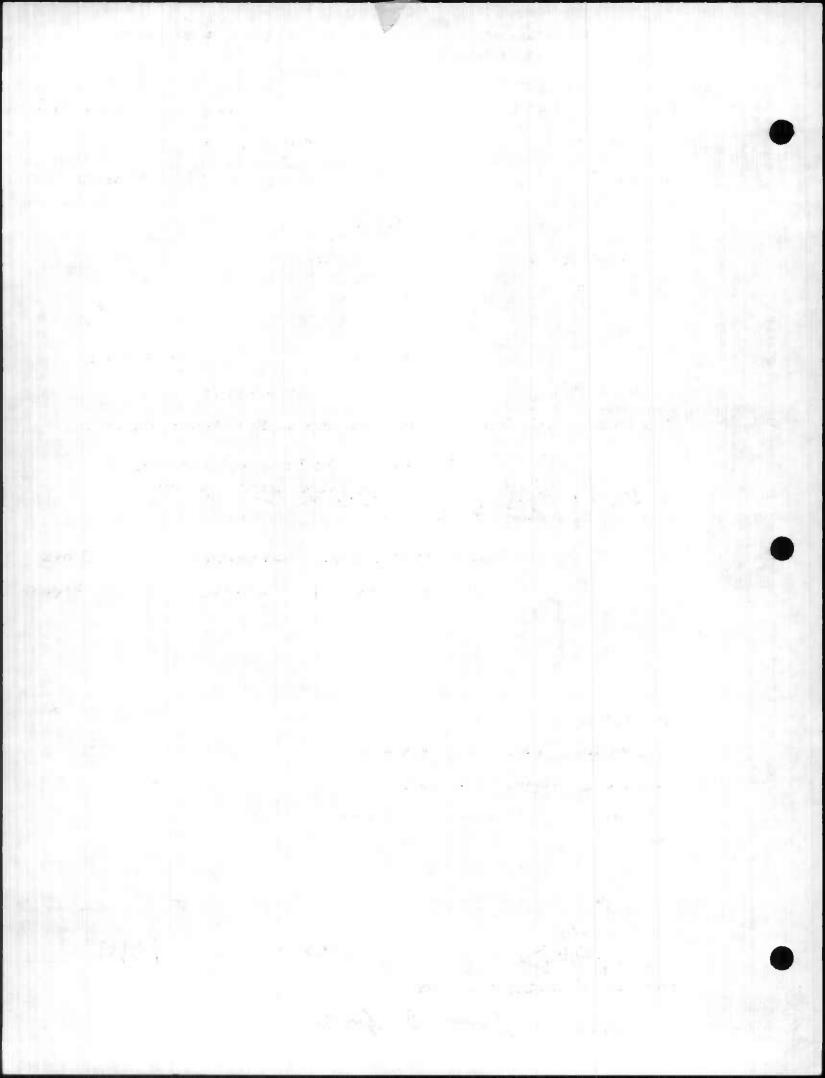
MAY 1 8 1999

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SURVIOE

32. Registrar's Signature Sporks

152 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the causa(s) and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year) 036312 impleted cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth HIGHTOW Month. 28 **Physician** /Medical 4e Facility Neme (If not institution 4b. City, Town, or Logation of Deeth 4c. County of Death Examiner ol t If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) 6698 Sex 1□ M 2DF Deys Months 244-34-N.C Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits Bolto Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Road USA Suter 21228 Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Specify Black Specify: Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Assistant NA tospital 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be fford Edwards 2 aria 196. Meiling Address (Street and Number or Rural Roya Number, City or Town, Stata, Zip Code) 346 Suter Road Cators Ville, Rd 2 19e. Informent's Neme/Ralationship (Type, Print) nd 346 phine Suter Hightower - Daughter 21228 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses Name end Address of Fecility 300 Avenue Wallast Inter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset end Death Immediata Cause (Final disaase or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert f. 23b. Did tobacco use contribute to the cause of death? 2 NO 3 Probably 4 Unknown 1 Yes by 24b. Were autopsy findings aveilable prior to Completed 24e. Wes en eutopsy epression completion of cause of death? Be 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 Residence 8 Other (Specify) 1 Nos 2 No Medical Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Netural 5 Pending investigation 1 Yes 2 Accident

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica To the http://within 24 hours.
To the Funeral Direc.

Funeral

Director

28a-f show

23a or 2

other traumatic avant, the Medical Examiner must be notified at

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Physician /Medical

Examiner

attending physician and for usa as the burial-transit

signed by to

page 2 s certificata

3 Suicide

29e. Certifier

4 ☐ Homicide

20th. Signature and tipe of certifier

31. Dete filed (Month, Day, Ye

6 Could not be

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1999

the Maryland

death Hema:

filed within 72 hours after

Baitimore, Maryland 21215-0020

State

Registrar

DHMH 16 Rev 6/95

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

29d. Date signed (Month, Day, Year)

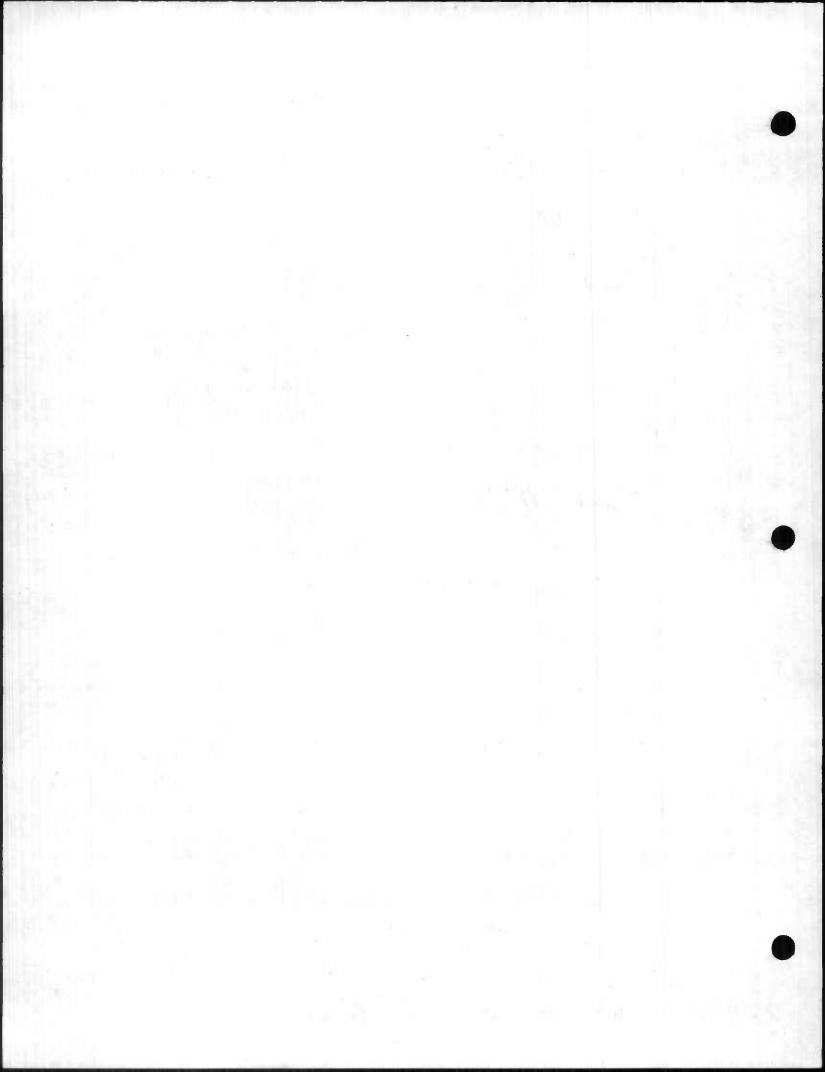
2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

m 23a) (Type, Print)

of death (Ite

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1999 **Physician** RTHUR HARRIS DANIEL 10:23 AH MAY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 62 BALTIMORE
M Under 1 Year M Under 24 Hrs. 8. Date d TROBE STREE 7 NIA 8. Date of Birth (Month, Day, Year) MAV 30, 19 7. Age (in yrs. last birthday) 5. Social Security Number Birthplaca (State or Foreign Country) 6 Sex **Funeral** Days Min 219-26-2875 Usual Residence of Decedent 10 M 20 F Months Hours Director 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f ahow be notified at Yes 2 No Director ALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? ò 1622 TROBE 23a STREE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Home ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after of health and Mental hygiena.

Artification of marked other than "natural", or feeling or or other traumite event, the Medical Engine in yor other traumite event, the Medical Engine. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ₺ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12++ GRADE SANITATION WORKER CITY OF BALTIMORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES HARRIS *ELIZABETH* JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4909 CHALGROVE SON AVENUE, BALTIMORE, Mp. 21215 DANIEL HARRIS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or CEMETERY 25-17-99 LANS DOWNE, MARY LAND 4 ☐ Donatien 5 ☐ Other (Specify) JR. FUNERAL HOME of Funeral Service Licensee 22. Name and Address of Facility
JOSE PH H. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arfest,

Approximate Approximate Intervat Between Onset and Death **Physician** congestive heart failure /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner pertension Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last physician the buria iabetes mellitus Due to (or as a consequence of) USe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23b. Did tobacco use contribute to the cause of death? 75-Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes No 2 No 1 Tes 25. Was case referred to medical examiner? 80 26. Place of Death (Check only one) TO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After Neturat

2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide

Division or Attending Hospital within 24 hor To the Fune completely fi # #

the Manyland

death

Baltimore, Maryland 21215-0020

68760.

Box

Records, P.O.

of Vital

State Registrar

Medicai

(Check only one)

29b. Signature and titte-of certifier

Kolght-MD 31. Date filed (Month, Day, Year) MAY 18

30. Name and address of person who completed cause of Seath (Item 23a) (Type, Print)

2323 32. Registrar's Signature

MI

29d. Date signed (Month, Day, Year)

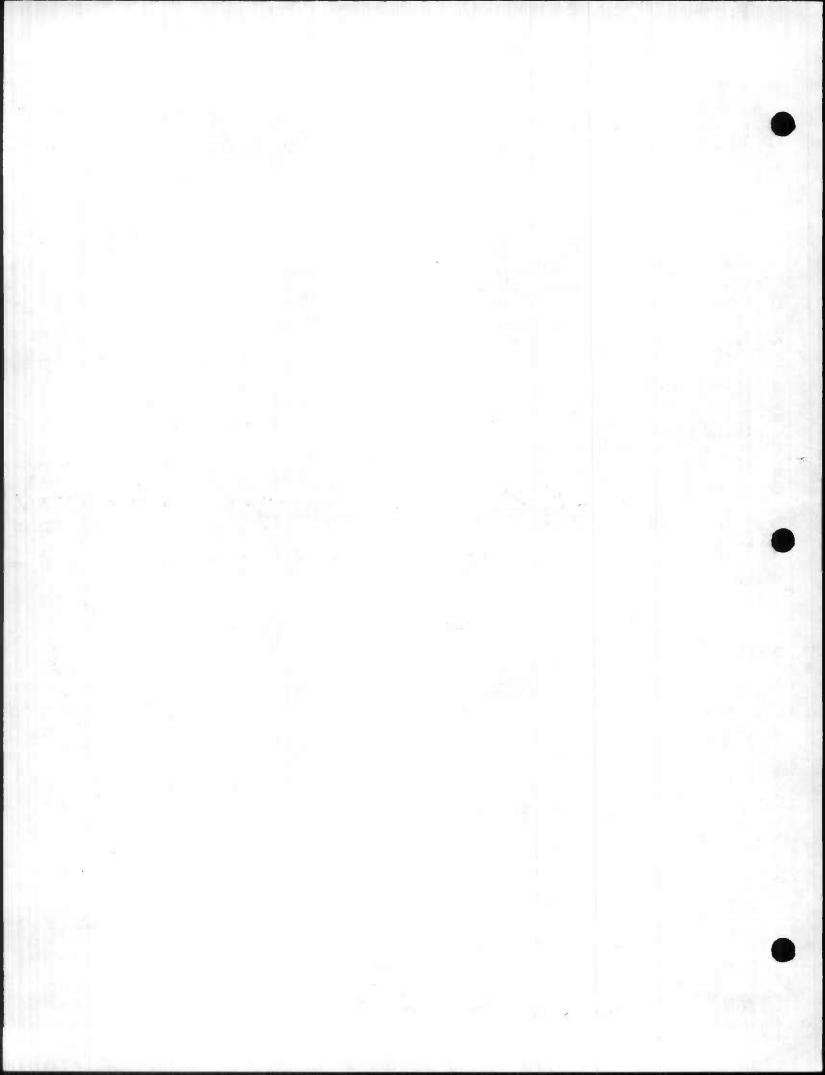
learn St., Baltimore, MD 21224

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the company.

niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 5:15 P.M. 15, 1999 CARL E HERSHBERGER JR. May 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, give street end number) 4c. County of Death Kosedale 7. Age (In yrs. lest birthday) Center Baltimore FRANKlin Da yare If Under 1 if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Dec 8 1920 5. Sociel Security Number 6. Sax 1 M 2 □ F Birthplace (State or Foreign Country) Months Days Hours Min. 217-14-3420 78 Mary Land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. **Baltimore** Essex 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 243 Orville Road 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Stafus 1 Never Merried 2 XMarried 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) Collaga (1-4or 5+) 10th Worker GM 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Carl Hershberger Mary M Clem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Norma Black / daughter 2510 Burgundy Drive Fallston Md. 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5/19/99 Holly Hill Cemetery Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Moshock, or heart feilure. List only she cause on each line. 300 Mace Ave. Baltimore Md. 21221 Approximate Intarvai Between Onset end Deeth Immediate Cause (Final disease or condition rasulting in death) · Fungal Sepsis 16 DAYS Sequentially list conditions, if any, laading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence ot): Bladder Perforation Due to (or as a consequence of): PNEUMONIA 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Artery Disease 24b. Wara autopsy findings available prior fo completion of cause of daath? 24a. Was an autopsy performed? INFARCTION 1 ☐ Yes 2 WNo 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

x 28a-f show

7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be

Director

Funerai

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Completed

Be

filed within 72 hours after death with the Maryland

Pages 1 and 2 should be filed with nent of Health and Mental Hygiene.

item 27 l

Department of Important: If any Injury or = 0

Hershberger, Car

Examiner sician and burial-trensit death certificate be executed physician a 98 esn for signed by the a

P.O. Box 68760

Division of Vital Records,

certificate this

funeral director. Certification:

Physician/Medical Completed by Be

or Attending Physician: 24 hours after death. filled in by Hospital within 2 the

Pert II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I.

25. Was cesa referred to medical examiner? Hospital: 1 Yas 2 No

5 Pending investigation

2 Accident 6 Could not be determined 3 Suicide 4 Homlcide

28a. Data of Injury (Month, Day Year)

1 M inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and this of certifier

27. Manner of Death

1 Natural

29a. Cartifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who complated cause of death (itam 23a) (Type, Print)

Jean-Max

May 15, 1999

31. Date filed (Month, Day, Year) MAY 18 1999 State

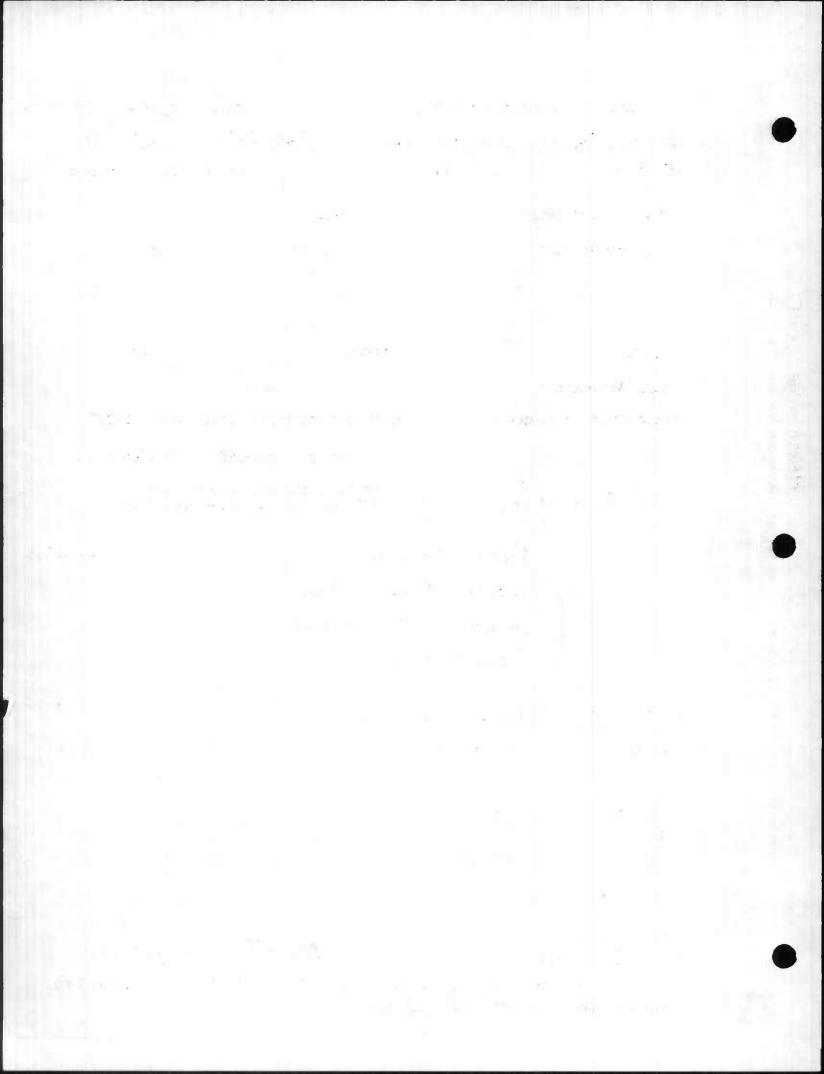
Medical

Hogarth, 9000 Franklin Square Drive Baltimore, MD 21237 32. Registrar's

DHMH 16 Rev 6/95

Registrar

0



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death ITEM: #23 PART I, PER MD 6771 5-18-99 WR. 1. Decedent's Name (First, Middla, Last) 2. Date of DeathMay-9-1999 Month 5:22pm A. Clara Howard 4b. City, Town, or Location of Death 4e Fecility Nama (If not institution, giva street and number) 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs. 8. Data of Birth Hours Min. Month, Day, April 27, If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months Days 1 M 2/0 F Yrs. Phila. Pa Usual Rasidence of Decedant 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Phoenix 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21131 U.S.A. 13800 Cripplegate RD. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - American Indien, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No Specify: White Specify: 3 Widowed 4 ☐ Divorced 15. Decedant's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Home Maker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Edward Niehaus Laura Puff 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Mrs.Barbara H. Smith / Daughter 13800 Cripplegate RD. Phoenix, MD. 21131 20b. Placa of Disposition (Nama of cametary, crematory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1XXBurial 2 ☐ Cramation 3 ☐ Ramovai from State 5/12/99 Parkville, MD. Moreland Memorial Park 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaçal/Sarvice Licensee Matthew T. Canapp 22. Name end Address of Facility 1050 York RD. Ruck Towson Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Towson MD. 21204 Approximata intarvai Batween Onsat and Daath Kespinatory Faulus WOOLD Immediata Causa (Final disaasa or condition rasulting in daeth) ASPIRATION PNEUMA Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Dua to (or es e consequance of): 23b. Did tobacco use contributa to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. ereoposis 2000 1 Yes 3 Probably 4 Unknown 24a. Was an autopsy periormad? 24b. Wara autopsy findings available prior to complation of cause of death? 1 □ Yas 2 □ No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred

Examiner Physician/Medical Examiner ettending physician and for use es the burial-transit

Physician

/Medical

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with the Maryland

Pages 1 and 2 should be filed within 72 hours efter death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic avent, the Medical Examinations must be notified.

Important: If it any injury or o

Physician

/Medical

toward,

been signated certificate hes b lirector, page 2 s After this funeral

The law requires that the death certificate be axecuted

b Completed Be 10 Certification:

edical

Division of Vital Records, P.O. Box 68760 or Attending after death. ector: / To the Hospital or A within 24 hours after To the Funeral Director completely filled in b.

29a. Cartifiar (Check only one)

1 Natural

3 ☐ Suicida

4 Homicida

2 Accidant

5 Panding investigation

6 Could not be dataminad

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

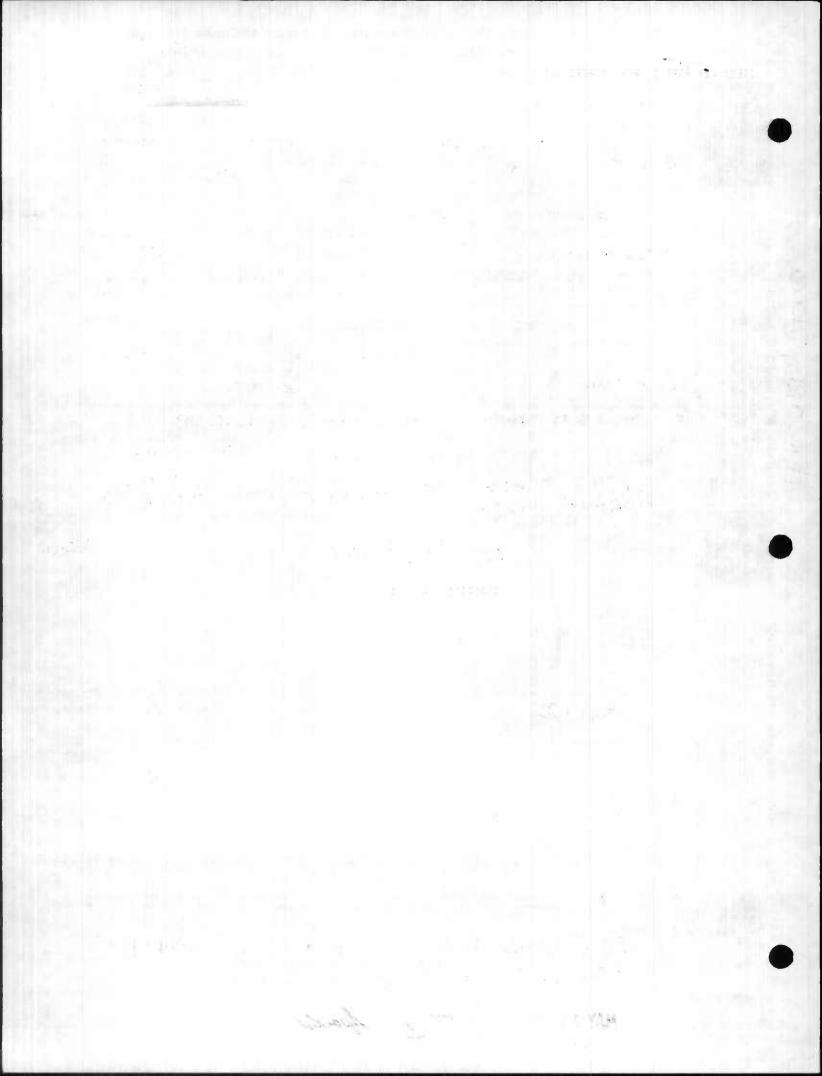
29d. Data signed (Month, Day, Year)

30. Nama and adirace of person who completed chusa of drafth (Itam 23a) (Type Print) 31. Data filed (Month, Day, Year)

State Registrar

MAY 1 8 1999





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle | ast) 2. Date of Death 3. Tima of Death Year **Physician** Edward Ambrose Hagens Jr. May 1999 14, 1:15 P.M. /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not Institution, give street and number) 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 M 2 □ F 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Months Yrs. 215-42-5058 Nov. Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 Glendower Ct.. Apt C 21237 U. S. A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Busineas/Industry Elementary/Secondary (0-12) College (1-4or 5+) Type Setter/Printer 12th Grade Printing Company 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Edward A. Hagens Sr. Frances M. Mugowski 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 7 Glendower Ct., Apt C, Baltimore, Maryland 21237 Diane Hagens (Wife) 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith 5/18/99 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signeture of Funerel Servica Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. Brian a. Wellem Approximate interval Between Onset end Deeth Immediete Ceuse (Finel disease or condition resulting In deeth) vars Due to (of es e consequence) of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice

attending physician and for use as the bunal-transit certificate be executed signed by the a peen 188 The certificate Physicien: this funeral al or Attending P s after death.

Division of Vital Records,

Funeral

Director

7 is marked other than "naturel", or itema 23a or 28a-f eho traumatic event, tre Medical Exaction must be notified at

filed within 7 Hyglena.

. Pages 1 end 2 should be fil iment of Health and Mentel H tant: If item 27 is marked oft

permit. Pages Department of Important: If it eny Injury or o

Physician

/Medical

Examiner

the Maryland

1:15pm

Edward

Physician/Medicai by Completed Be To Certification:

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1 Tes	2 No

27. Manner of Deeth 1 Natural

2 Accident

3 Sulcide

4 Homlcide

28e. Dete of Injury (Month, Dey Year) 5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury et Work?

1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a, Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner es atated.

2 Medical Examinar: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture end title of cartille

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end address of parson who completed cause of deeth (Item 23e) (Typa, Print)

W.A. Riley N. Charles ST. Balto Md GBMC 6701

31. Date filed (Month, Day, Year)
MAY 1 8 1999 32. Registrer's Signeture

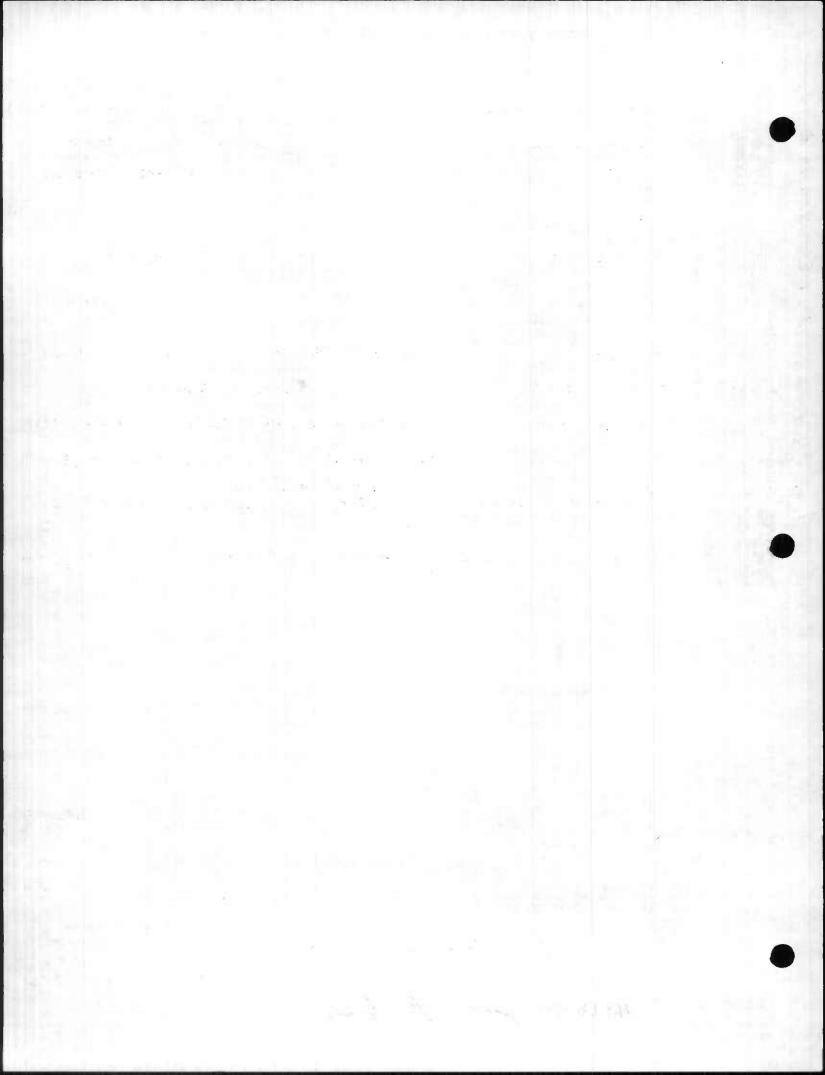
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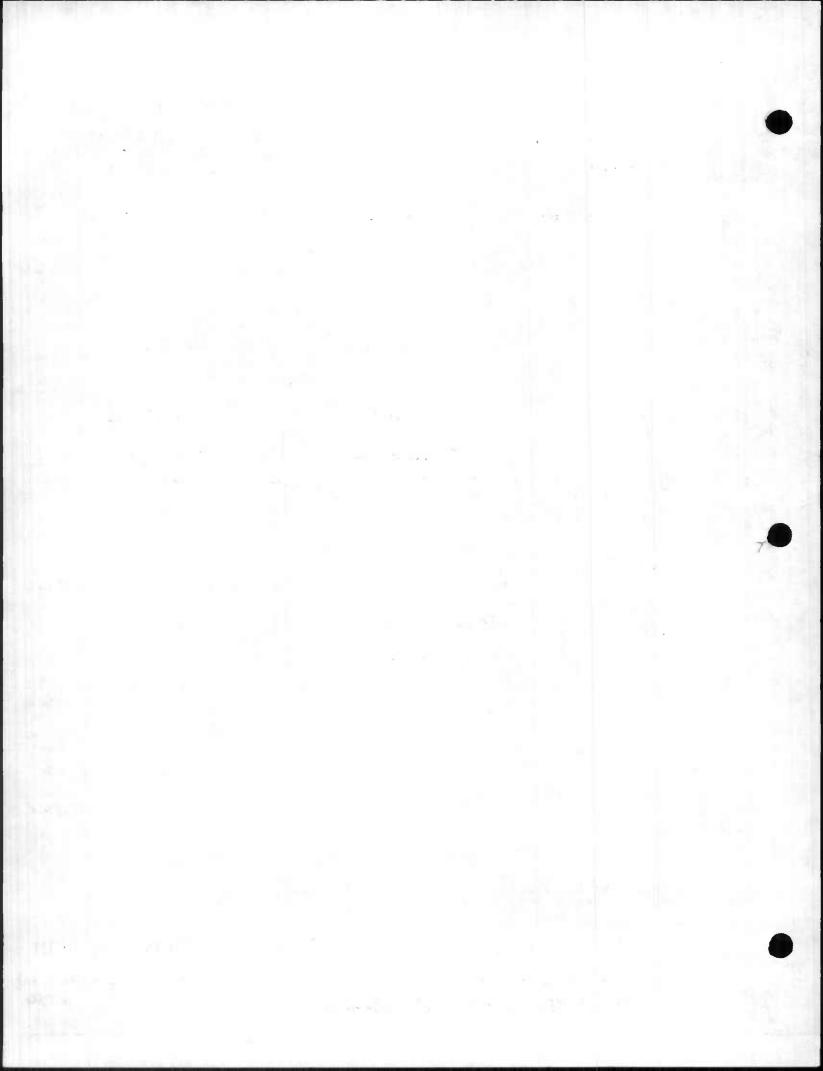


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** Catherine Hatfield Anna 1999 9:16 AM MAY 16 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 13, 1908 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F 90 216-03-3816 Vrs Maryland Director Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumetic event, the Medical Examiner must be notified at 1 Yes 20 No Directo Abinadon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3837 Memory Lane, 21009 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify. Specity: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Clothing Office Worker 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be fill Department of Health and Mental Hy Important: if Item 27 is marked other any Injury or other treumatic event 17. Father's Name (First, Middle, Last) Be Charles Albert Clara Frese 0 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Mrs. Anne C. Hilbinger (dghtr) 7 High Button Court, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State Baltimore National Cem. 15/19/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23e. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximate Interval Batween Onsel end Deeth Physician C/Medical Immediate Cause (Finel disease or condition resulting in death) Éxaminer TO PERITONEAL METASTASIS be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last and TERINE Box 68760 physician Physician/Medical Due to (or es a consequence of): the BONY attending p ETASTASIS P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 D Unknown á 1 ☐ Yes 2 ☐ No been signed t should be deta Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 DING t Yes 2 No certificate Division of Vital i or Attending Physician: after death. Director: After this certific 25. Was case raferred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOS / ICE 1 Yes 20 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture englittle of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (item 23a) (Type, Print) -NORTH AVENUE BEL AIR MARYLAND MAHMOOD 31. Date 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

HATFIELD, ANNA

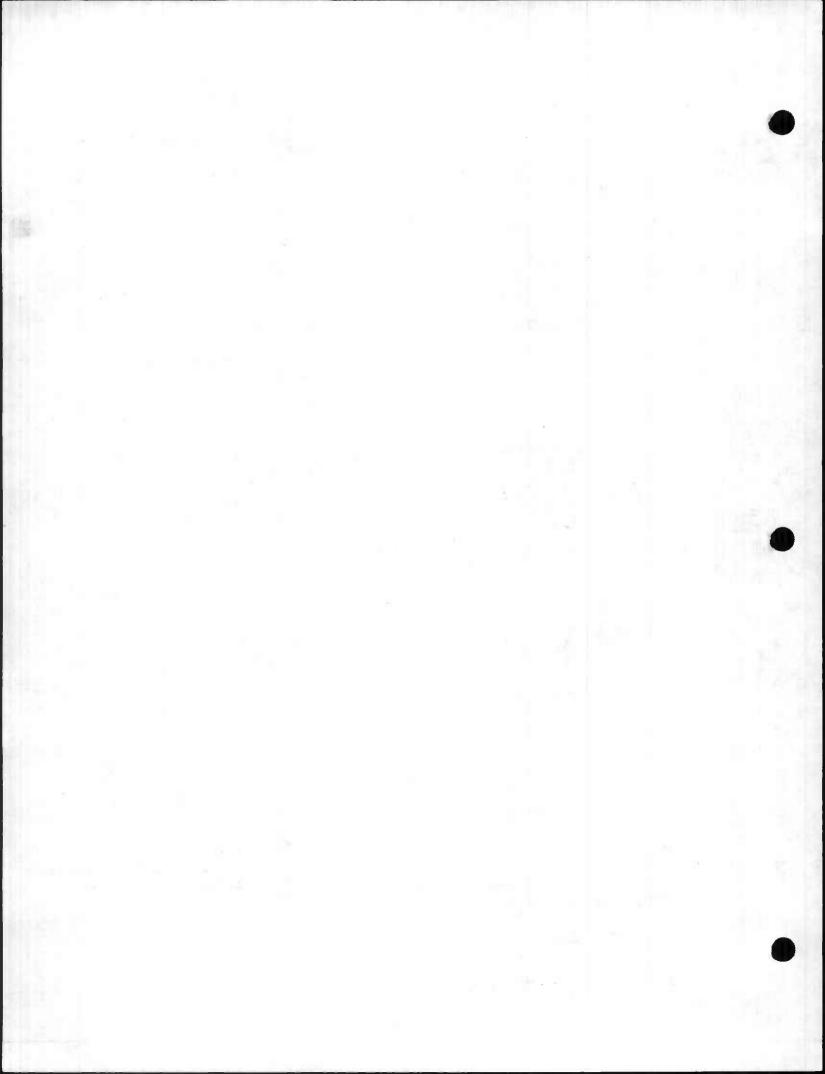


State of Maryland / Department of Health and Mental Hygiene O. O.

HOGAN		Otato or man	Ce	rtificate of			Reg. No.		2002
	1. Decedent'a Name (First, Middle, Last)					2. Date of Dea	th	W	3. Time of Death
Physician /Medical	Duane Louis Hogan					MAY (08, Dey 1.999	Year	8:30 PM.
Examiner	4a Facility Name (If not institution, give :	street and number)			4b. City, Town, or I	Location of Death	4c. County	of Death	
	ANNE ARUNDEL GEI	NERAL HOSPI	ITAL		ANNAPOLI	S	Anne	Arun	del
Funeral Director	5. Social Security Number 6. Sex 112	7. Age (III	n yrs. last birthday) Yrs.	Months Days			, Year)		place (State or Foreign
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deeth with the Meryland one 23e or 28e-f ahow if must be notified at neral Director	10a. State 10b. County		oc. City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yas 2 ☐ No
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D P O	15004 Tarleton Driv			10f. Zip Code 20120			log. Citizen of N United		
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020 ura after aff, or the by Fu	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Hispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		ck, White,	etc.
5-0 72 ho	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occu	pation	ting	16b. Kind of B	usiness/In	dustry
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aryian should be and Mentel a marked o umartic ava	William F. Hogan				Stella A				
Mary 12 sho 12 sho 14 mand M	19a. Informant's Name/Relationship (Typ				end Number or Ru				
ges 1 and 2 t of Health If Nam 27 i or other tru	Sharon Hogan - daug				Avenue,				
Baitimore, semit. Peges 1 er Separtment of Hee mportant: if Item 2 my Injury or other and Item 2 mort.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ R	emoval from State	cemetery, cre	osition (Neme of matory or other pla	ce)	Date	20c. Location	City or 10	own, State
ting the tant:	4 Donation 5 Other (Specify)			lemorial :		5/14/99			rginia
Baitim, permit. Peg Department Important: I any Injury of page.	21. Signature of Funerel Service License	Bink	22	2. Name and Addre	ess of Facility Ev	verly Fur 1565 Main Lirfax, V	neral Ho Street Virginia	ome 1 2 22	030
	23a. Part1. Enter the disease, or compliant shock, or heart failure. List only or	mons thet caused the	death. Do not en	ter the mode of dyi					Approximate Intervel Between
Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	Due	hes to (or as a conse	quence of):	Inj	urie	S	1 1 0 0	
68760, tificate be associted to physician and as the burla-transit fedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e to (or es a consec					1	
dS, P.O. Box (lires that the death certif signed by the attending d be deteched for use as d by Physician/Me	d								
tha dea yy the a nched fi	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	inderlying cause gi	ven in Part I.	23b. Did to	obacco uae co	ntribute t	o the cause of death?
P.O. that the sed by the deteche						101	es 20 No	3 Pro	bably 4 Unknown
cords, v requires the been signed should be defected by	-					24a. Was a		24b. W	ara autopsy findings
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Y Vital Re yaiclen: The id yaiclen: The id is certificate he director, page To Be Com						1 🗷 Y	es 2 No	11	OYes 2□ No
Vital I	25. Was case referred to medical examiner?	lospital:		l ne	hor	ath (Check only or			
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Division o To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	(Check only 2 X Medical Examin	ician: To the best of mer: On the basis of exa	y knowledge, deat	h occurred at the ti	me, date end piece	, and due to the c	ause(s) end m	onner as s	atated.
within 2 To the P complet	one)	and manner atated	•						
5 × 5 × 5	29b. Signature and title of certifier	(10)		29c. Licen	The second second		29d. Date signe		
, 0	Jellan	en, 101-	り	0	.C.M.E.		MAY 10), 19	99
10	30 Name and address of person who con	mpleted cause of death			t, Baltim	ore, Mar	yland 2	21201	
State Registrar	31. Date filed (Month) Day, Year) MAY 1 8 1999	32. Registrar's		books					

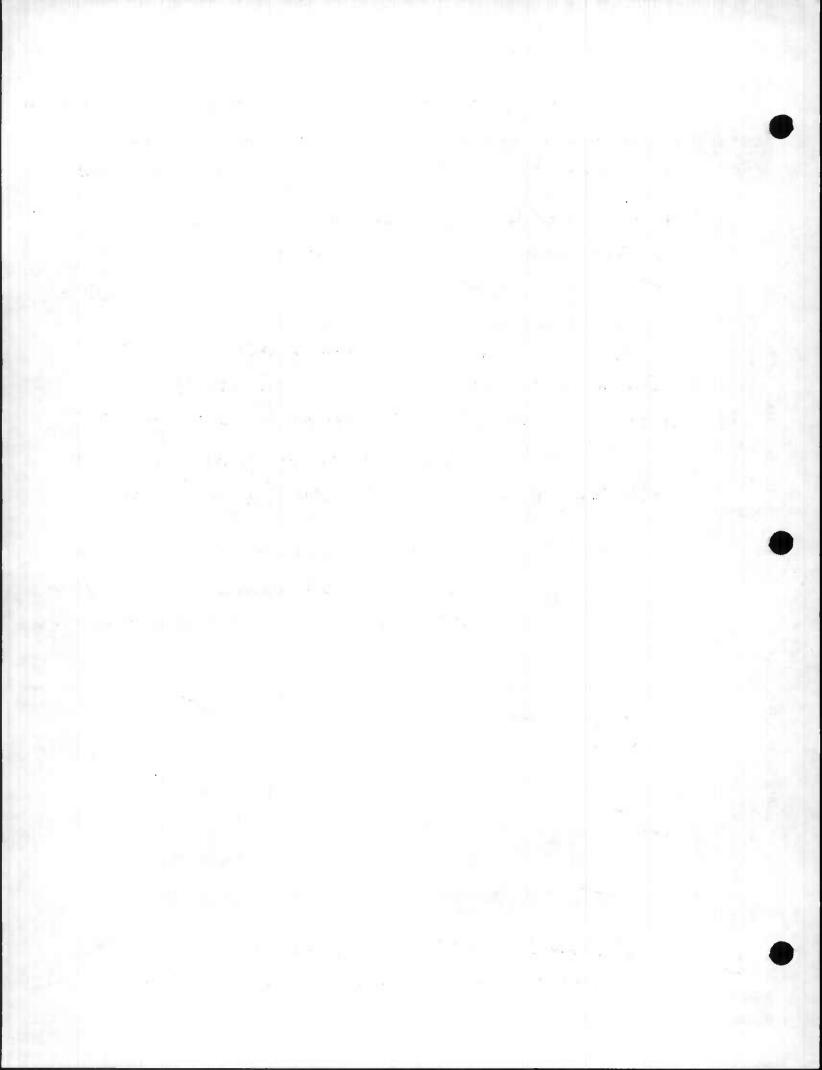
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Discount of the same	1. Decedent's Name (First, Middle, Las	1)				2. Dete of Deat Month		3. Time of Death
Physician /Medical	Thomas, M	. INGOGE	-iA			MAY	14, 19	199 1:30 AM
Examiner	4a Facility Neme (If not Institution, give			-	4b. City, Town, or Lo	cation of Deeth	4c. County of	Death
	MEDICAL POINT A	oursing Home			ELKTON	3	CE	cil
Funerai	5. Sociel Security Number 6. S	7. Age (In yrs	. last birthday)	If Under 1 Year		8. Date of Birth (Month, Day,	Vacel	Birthplace (State or Foreign Country)
Director	212-62-7042 A 1 Usual Residence of Decedent	DM 20F	Yrs.	Months Days	Hours Min.	Dec, 8	1951	MD
arylend	10a. State 10b. County		ity, Town or Loca	_				10d. inside City Limits
Ba-f	MO CE	CIL	E	KTON				TEJ 195 2 LANG
vith the Mar or 28a-1 s	10e. Street and Number			10f. Zip Code	0.0	1	0g. Citizen of Wh	
eth v	1 PRICE DRIV			9	1421			S.A
s 1 and 2 should be filed within 72 hours efter deeth with the Maryland for Haalth and Mental Hygiene. It health and Mental Hygiene. Other traumatic event, the Medical Examinat must be notified at the To Be Completed by Funeral Director.	11. Marital Status 1 Never Married 2 Merried	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give		s Decedent of Fes, specify Cub	lispanic Origin? (Spe en, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indien, White, etc.
hours tural	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a Deceder	nt's Usual Occup	etion		16b. Kind of Busi	00
ed within 72 hours of ygiene. Nor than "natural; or it, me Medical Exam. Completed by I	(Specify only highest gra-	de completed)	(Give kir	nd of work done NOT use retire	during most of worki	ng	TOD. THIS OF DOOR	incount about
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should and Men marke umatic	19a. Informent's Neme/Relationship (7	=	19b Mailing	Address (Street	end Number or Rure	-		tete. Zin Code)
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ges 1 end t of Health If item 27 or other tr	20a. Method of Disposition		Plece of Disposit	ion (Neme of		0		ity or Town, State
80 = 6	1 ☐ Buriai 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crema	tory or other pla				
nit. Pag entment ortant: If Injury o	4 Donation 5 Other (Specify		reenmour	IT COM	etery 5	15 99	(3m)	TO.MD.
permit. Pa Depertmen Important: any injury once.	21. Signative of Funeral Service Licen	Willer	22.1	HARTLE	ss of Facility Miller F Ford. RD	ineral +	tom CH	FTD. 1274
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leath cert attendin d for use	Part II. Other significant conditions co	natibuting to death but not re-	aultina la the und	advine source sh	ren in Red I	22h Did to	hace use contr	ribute to the cause of death
that the death certified by the attending deteched for use if	500-0	2	saking in the ana	enying cause gr	enin Parti.	1250. DIG 10	_	3 Probably 4 Unknow
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ysicien: The law s certificate hes director, page 2						1 🗆 Y	s 2DNo	1 ☐ Yes 2 ☐ No
	25. Was case referred to medical				26. Place of Beatl	Check only on	(e)	
Physician: this certific ral director,	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DOA Oth	ner: 42 Nursing Ho	me 5 Reside	ence 6 Other	(Specify)
To the Hospital or Attending Phys within 24 hours efter deeth. To the Funeral Director: After this completely filled in by the funeral di	27. Manner of Death → ■Naturel 5 □ Pending 2 □ Accident investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. fnju Wo M 1			ow Injury occurred	
tal or Attending P rs efter deeth. al Director: After tied in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec		t, factory, office		28f. Location (Si City or Town		r or Rural Route Number,
the Hospitathin 24 hours of the Funeral mpletely fille	29e. Certifier (Check only one) Certifying Physics (Check only one)	valcian: To the best of my kn Iner: On the basis of examin and manner stated.	owledge, death o ation and/or inves	ccurred at the til stigation, in my c	me, date and plece, opinion, death occurr	and due to the coed at the time, d	ause(s) and man ate and place, an	ner es steted. nd due to the ceuse(s)
Neithir Neithir Comp	29b. Signeture and title of certifier			29c. Licens	se number	2	9d. Dete signed	(Month, Dey, Year)
F > F 0	1 1 1	Non - MIN		-	7 22 7 7		5/11	1/90
6	30. Name and address of person who						0 /19	2.00
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State Registrar	31. Date filed (Month, Day, Yeer)	32. Registrar's Sign	se G	. Soo	els.			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** IDA Jones May 16 1999 11:18 am /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Baltimore 7. Age (In yrs. lest birthdey) | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth Months | Deys | Hours | Min. | 01/13/1920 Johns Hopkins University Bayview Medical Center Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 200 Director 215 52 2568 Usual Residence of Decedent death with the Maryland Hydene. Other than "natural", or itsms 23e or 26e-f show ent, fre Medical Evantiner must be notified at 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Director BALTIMORE TURNERS STATION 10e. Street end Number 10a. Citizen of Whet Country? 10f. Zip Code 108 CHESTNUT ST. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 11 Meritel Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes XXNo 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 8 DOMESTIC HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If flem 27 is marked othe any injury or other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be PAUL JACKSON ISABELLE IRVIN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Piece of Disposition (Name of cemetery, cremetory or other place) THOMAS M. JONES/SON Dete 20c. Location - City or Town, Stete 20e. Method of Disposition

1 Burial 2 Cremetion 3 Remove from Stete CROWNSVILLE VET. CEM 5/20/99 CROWNSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. mes qu 1701 LAURENS ST. BALTO., MD 21217 Part Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximete Intervet Between Onset and Death Ph_sician Immediete Ceuse (Finel disease or condition resulting In death) /Medical Diabetes years Due to (or es e consequenca of): Examiner Examiner physician and s the burial-transit The law requires that the death cartificate be asscuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequenca of): Records. P.O. Box 68760. Physician/Medical Due to (or es e consequence of) for use as ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed to Porkinson by 24a. Wes an autopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed Bipolar disorder nis certificate has b I director, paga 2 sl 2 No 1 ☐ Yes 1 □ Yes 2 □ No Hypertension Division of Vital Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA P s after dea... rsi Director: After un-28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 PNaturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - Al home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide ò To the Hospital of within 24 hours at To the Funersi D completely filled in edical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture end title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

31. Dete filed (Month, Day, Year)

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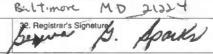
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30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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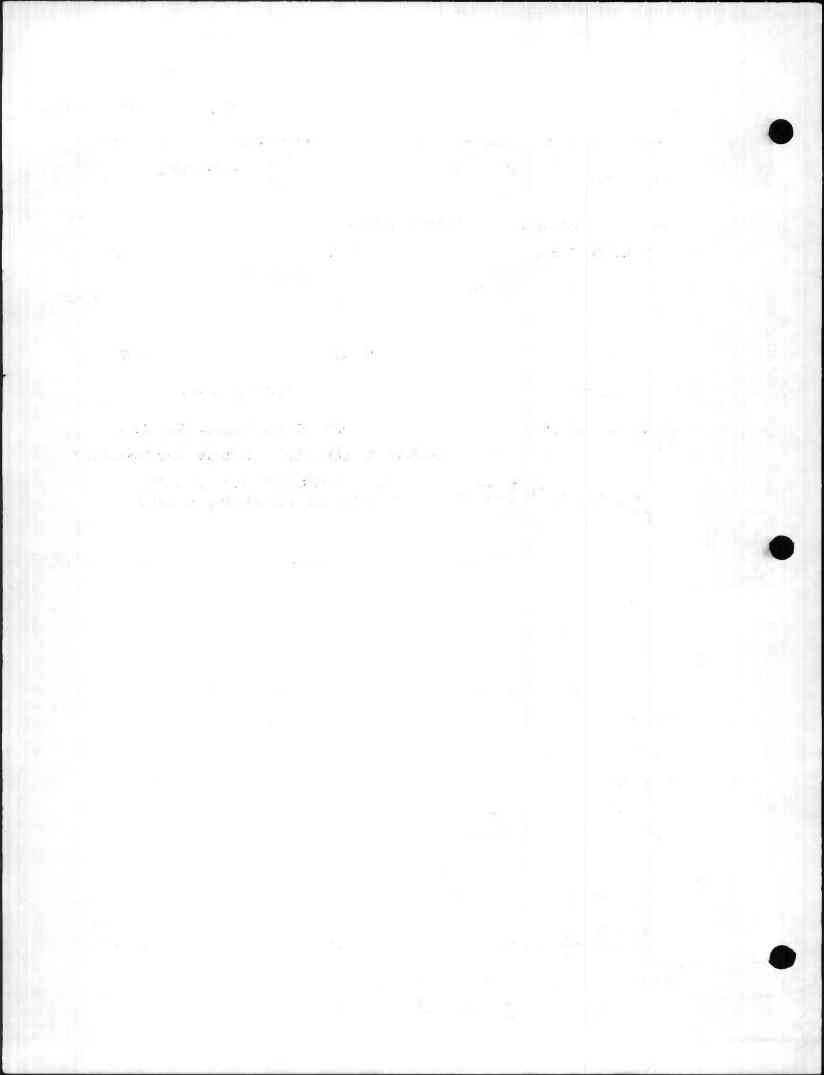
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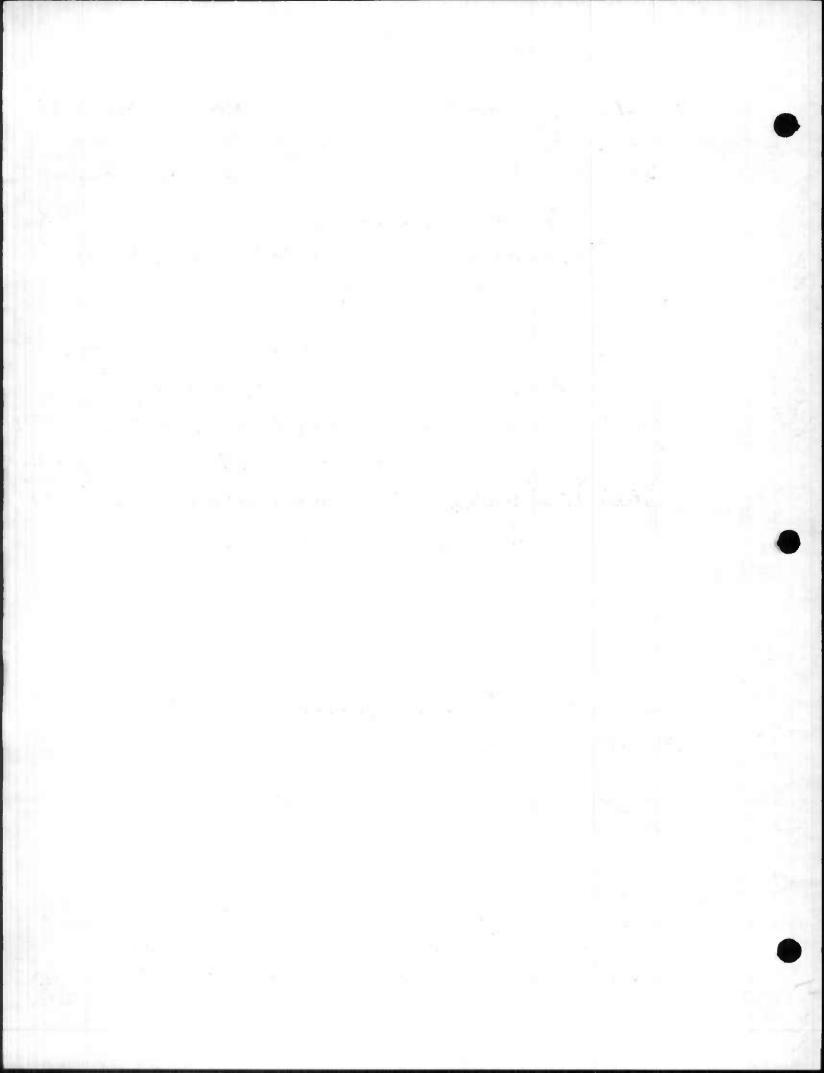
May 16



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Lest) 2. Dete of Deeth Month **Physician** 0330 MA /Medical 4e. Fecility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of De Examiner CA fons VIlle
If Under 24 Hrs. 8. Date fimore ores 5. Social Sacurity Number If Under 1 Yaar 7. Aga (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthpleca (Steta or Foreign Country) **Funeral** 1□M 2 F 216 05 08/5 Usual Residence of Decedent Deys Yrs. Director September 7,1917 Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director Himore on Suill 28s-4 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Lngleside therms 23a States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Merried 2 ☐ Married "natural", or 1 ☐ Yas 2 No Baltimore, Maryland 21215-0020 þ specify: White 3 Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Hone marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be Health and Mental mat 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or important: If Item 27 any injury or other tr ber KITWAN Son 11210 Yardley , MD. 21754 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stata 8 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerei Service Licenses 28 Ambrose tuneral Home Arbutus 23a. Part1. Entar the disease, or complications that caused the shock, or heart feilure. List only one cause on each line. Do not enter the moda of dying, such es cardiec or respiratory errest, Approximete Interval Between Onset and Death **Physician** NEUMONIA SPIRATION /Medical Immediate Ceuse (Fine) diseese or condition resulting in deeth) **Examiner** Dua to (or as a consequence of) Examiner Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consaquence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 4 Hiknown 1 ☐ Yes 2 ☐ No ABETES MEZLITUS Records, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? self-Rosis page 2 2 1No 1 Yes 1 Yes 2 No Vital this certificate To the Hospital or Attending Physician: within 24 hours after death.

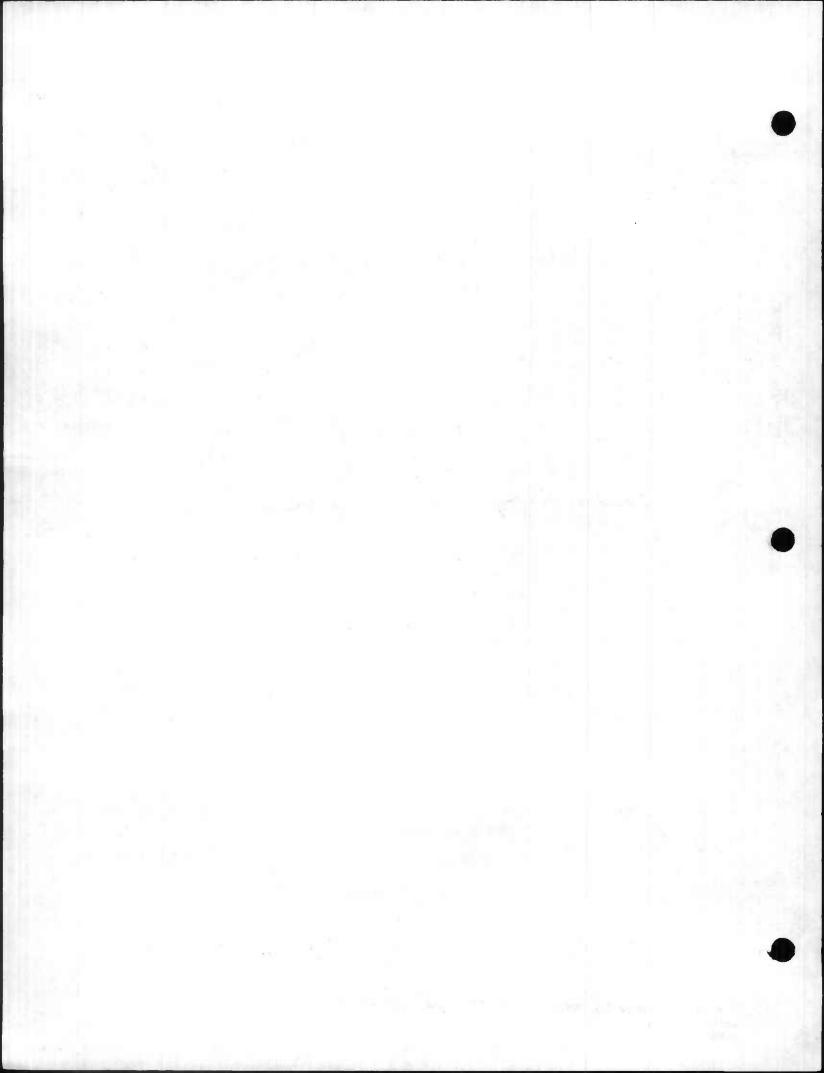
To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Wes case referred to medical exeminar? 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturei 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 4 Homicide Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end manner stated. 29a. Certifier edical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yaar) 17 30. Name and address of person who completed ise of deeth (Item 23e) (Type, Print), MASNEEM 7220 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 21200 Registrar MAY 1 8 1999



State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner			Certifica	te of Death		Reg. No.	10000
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Funeral Director	5. Social Security Number 6. Se 216-01-6452	PX PX P 7. Age (In yrs. 1	last birthday) If Und Months	er 1 Year If Under 24 Hrs Days Hours Min		th ly. Year)	9. Birthplace (State or Fore Country)
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23a or 2 unit be n	1300 S El	lewood	aue 101.2	ap Code 2/224	/	10g. Citizen of W	That Country?
n 72 hours after death with the Maryland "natural", or itema 23a or 28a-f show redical Examiner must be notified at leted by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puel 20 No Specify:	Specify Yes or No to Rican, etc.)		- American Indien, k, White, etc.
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ng Ph ther th neral	27. Manner of Death 1 ☑Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurre	ed
	2 ☐ Accident investigation		М	1 Yes 2 No			
beth.	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ory, office	28f. Location (City or To		er or Rural Route Number,
or Attenda after deeth. Director: A d in by the fi		raician: To the best of my know	wledge, death occurre	d at the time, date and plac	e, end due to the	ceuse(s) and man	nner as stated.
b Hospital or Attanding P 24 hours after death. Funeral Director: After t etaly filled in by the funeral dical Certification:	29a. Certifier Certifying Phy (Check only one)	Iner: On the basis of examinate and manner stated.	ion and/or investigatio	n, in my opinion, deeth occ	urred at the time,	date end piece, a	ino due to the cause(s)
to the Hospital or Attandi within 24 hours after deeth. to the Funeral Director: A completaly filled in by the tr Medical Certificati	(Check only 2 Medical Exami	Iner: On the basis of examinat		n, in my opinion, deeth occ 9c. License number	urred at the time,	29d. Date signed	(Month, Day, Year)
To the Hospital or Attandi within 24 hours after deeth. To the Funeral Director: A completely filled in by the it Medical Certificati	(Check only 2 Medicat Exami	Iner: On the basis of examinat			urred at the time,		
n 24 hound n 24 hound	(Check only 2 Medicat Exami	Iner: On the basis of examinat and manner stated.	2		L Unred at the time,	29d. Date signed	



State of Maryland / Department of Health and Mental Hygiene

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L ITEMS	: #23 PART I	, 27, 28A-F	PER MEO	G771 5-25	WR . Ce	ertifica	ate of	Death		Reg. No.	5	13090
Physician	Decedent's Ner	me (First, Middle, Li RT ALLEN I	ast)						2. Date of Do Month MAY	Day 13, 199	Year 19	3. Time of Deeth 5:21 PM.
/Medical Examiner		(If not institution, gi				-		4b. City, Town, or	Location of Dea	th 4c. Count		
		HOPKINS				vi Millerd	ser 1 Year	BAL ¹ If Under 24 Hrs	TIMORE	N/		
Funeral Director	5. Social Security 216–56–5	5430	Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 48	Yrs.	Month		Hours Min		750 Year)	9. Birth	place (State or Foreign NO) YLAND
1	Usual Residence	of Decedent 10b. County		10c. Ci	ity, Town or I	Location						10d. Inside City Limits
at, or tems 23s or 28s-f show Examiner must be notified at the Funeral Director		BALTIM	ORE		IDGELE							1 ☐ Yes 🏖 ☐ No
Director	10e. Street and N		J.(L)			-	Zip Code			10g. Citizen of	What Cou	ntry?
4 0		YAKONA ROZ	ΔD				212	3/		USA		
by Funeral	11. Marital Status		12. Was Dec Armed Fo 1 X Yes If Yes, Gi	2 No	J,S. 13		pedent of F pecify Cub	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		ce - Americk, White	ican Indian, , etc.
ted b	SEJ WILLOWS	15. Decedent's E	Year or E		16a. Dec	edent's Us	suaf Occup	pation	arkina	16b. Kind of E		
Completed	Elementary/Sec		College (1-4or 5+)				during most of wo		D.1.	1000	00 00111
Con	15.5		4 YEAR	RS	ENG	INEEF	KING	ASSISTAN				CO. GOV'T
Be	17. Fether's Nemo	e (First, Middle, Las							me (First, Middle		me)	
L	MILLIA	AM KUSZMAI							HARLFIN			
		Neme/Relationship		OTHER				ROAD BA			. Stete, Zi . 234	p Code)
		sposition Cremetion 3 [5 Other (Speci		State	Place of Disposeries, cr RRISON	emetory or	r other pla	ET. CEM.	Date 5/19/99	20c. Location OWING		own, State
		unerel Service Lice						ss of Fecility N FUNERA				
any injury or other treumatic event, the Medical Exponen. To Be Completed by	1	11/2/			100			RAVEN B		OWSON, M	1D 2	1286
ian cal ner	Immediate Cause disease or condit resulting In death	ion		RCOTIC AND		NE INT	OXICAT				3 3 5 5 3	Intervel Between Onset and Death
Physician/Medical Examiner		conditions, immediate Jerlying or injury its) Last	b		or as a cons							
hysicia	Part II. Other sign	ificant conditions	contributing to d	eath but not res	sulting in the	underlying	g cause giv	ven in Pert I.		l tobacco use co		to the cause of death?
by P	-											
Completed									24a. Wa peri	s en eutopsy ormed?	a	Vere autopsy findings vaileble prior to ompletion of cause f death?
Comp	-, -,-								15	les 2□No		☐ Yes 2☐ No
Be	25. Was case refe examiner?	erred to medical							eth (Check only	one)		
2	14 Yes 2				ER/Outpati		DOA		Home 5□Res			ity)
Certification:		5 Pending investigation	" 5_13_0	of fnjury th, Day Year)	28b. Tima Injury Found:		28c. tnju Wo	ryat rk? ∣Yes 2X□No	28d. Describe	how injury occu	rred	
Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		of Injury - At hing, etc. (Special	nome, ferm, s	street, fecto	ory, office		28f. Location City or To	(Street end Num	ber or Ru	ral Route Number, NYON ROAD,
Cen				OUND: OU						RE MARYL		
edicai			hysician: To the miner: On the b	best of my kno asis of examine	owledge, dea	ath occurre		me, date and plac opinion, deeth occ				
Me	29b. Signature an	d title of certifier	and men	ner steted.		2	29c. Licens	se number		29d. Date sign	ed (Month	, Dey, Year)
		11-5	11/6	.00.				D.C.M.E.		MAY 1		
	30. Name and add	ires of person who	completed caus	se of death (Iter	m 23a) (Type	e, Print)						

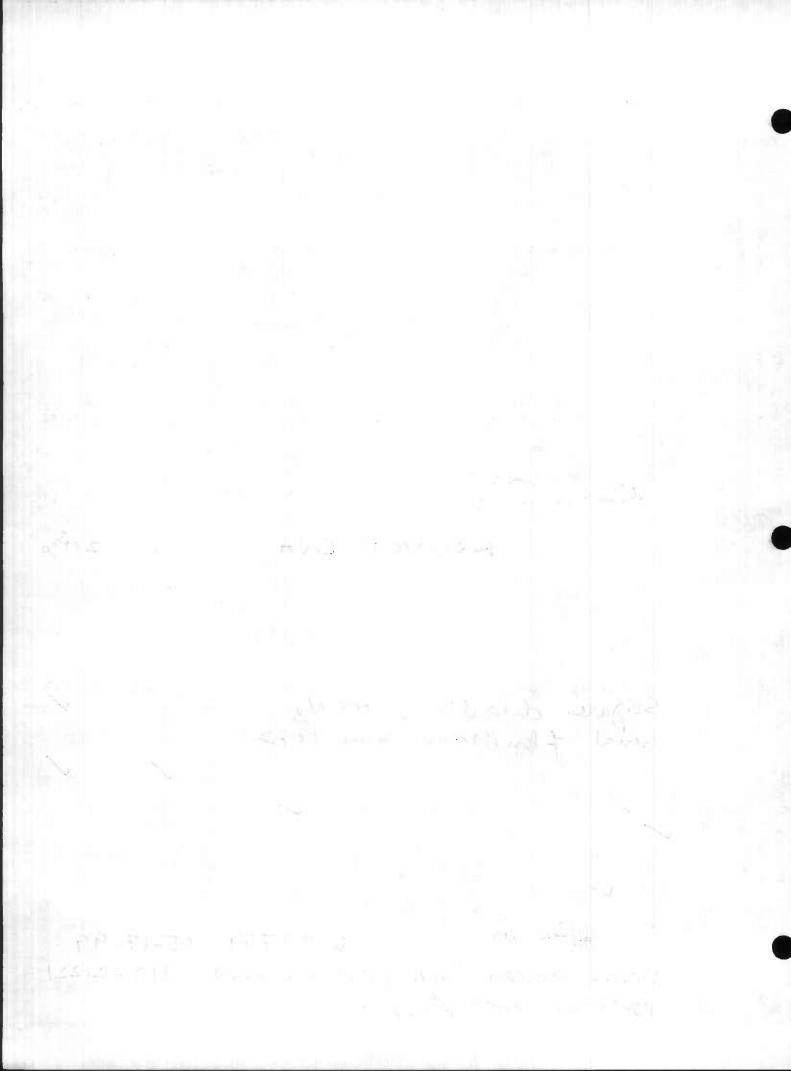
State Registrar

31. Date filed (Month, Day, Year) MAY 1 8 1999

Koroli 111 Penn Street, Baltimore, Maryland 21201

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					oi Mai	ryiand / L	Certifica		Death		Reg. No.	1589	91
	hysician /Medical	Decedent's Name Rut			kta					2. Date of Do Month May	Dey	3. Time o	Death p.m.
100	xaminer	4a Facility Name (/	f not institution	n, give street and n	umber)				4b. City, Town, or Li	ocation of Deal	h 4c. County o	Death	
	ineral rector	Manor 5. Social Security N 220-07-8	umber	Rossville 6. Sex 1 M 2 XF		(In yrs. last bir	thday) If Un Month	der 1 Year hs Days	ROSSVII: If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 12-25		imore Co. 9. Birthplace (State of Country) Marylan	
deeth with the Maryland	ě u	Usual Residence of 10a. State	Decedent 10b, County		1	10c. City, Tow	n or Location					10d. Inside C	
M.	of of	Maryland		N/A		Balt	imore					1 🛣 Yes	2 No
£ :	or 28-7 be noutles	10e. Street and Nur	nber				10f.	Zip Code			10g. Citizen of Wi	nel Country?	1
3 5	1 E	432	9 Harf	ord Road					21214		United	States	
_ 5	rai, or terms 23a or 284- show Exercise must be notified at 1 by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		H Vac G	Forces? 2 [X]No Sive		If Yes, s	cedent of H pecify Cubi 2 X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Bleck Specify:	American Indian, White, etc.	
T C 1	t, the Medical E.	(Speci Elementary/Seco Unkno	ify only highe ndary (0-12)	t's Education st grade completed College	(1-4or 5+)		life. DO NO	sual Occup work done Tuse retired	pation during most of work d)	ing	16b. Kind of Bus	iness/Industry	
D ET	8	17. Father's Name								e (First, Middle Ostorf	, Maiden Sumeme)	
aryla should and Men	To de	David 19a. Informent's Na				10h	Mailing Adds	ass (Straat	ROSa and Number or Rur		- 4	tate 7in Code)	
20 00	d d	Mr. John			(son)				Avenue		ore, Mary		234
Te, N	other tr	20a. Method of Disp		33	(3011)	20b. Plece of	Disposition (/	Vame of	1	Date		ity or Town, Stete	-54
0 50	707	1 ☑ Burial 2 0 4 ☐ Donation		3 Removel from	n Stete		loly Re			/18/99	Raltimo	re, Maryl	and
Baltimore,	eny injury	21. Signature of Fu			æl E.	Canapp	22. Name	end Addre	J. RUCK,			rford Roa	
		23a. Part1. Enter th	ne disease, or	complications thet	caused th	ne death. Do r	1		ng, such as cardiac			Approxime	ite
/Me	ician dical	Immediate Cause (Finel	only one cause on	_		rent	- 0	LVA			Intervet Be Onset and	
	niner	resulting in death)			D	ue to (or as a	consequence (of):					1111
58760, cate be executed	physician and a the burlei-transit and cal Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, mediate rlying injury	6.	D	ue to (or as a o	consequence o	of):					
		that initiated events resulting in death) I		d	Di	ue to (or as a c	consequence o	of):					
Box	Clar											1	
P.O.	thy seches	Part II. Other signiff Sei	JWC-			A			4			ributa to the cause 3 ☐ Probably 4 €	Of death?
of Vital Records, Physician: The law requires the	phould be be be be be be be be be be be be be	ari	عا	J-lavi	lla	hav,	, Sev	ere	N,	248. Was perf	en autopsy ormed?	24b. Were eutopsy available prior completion of of deeth?	to
I Rec	omp Somp			<i>V</i>						10	Yes a No	1□Yes 2€	No
E :	director, page	25. Was case refer	ed to medica						26. Place of Deet	th (Check only	one)		
of Vita		examiner?	No	Hospitet: 1	Inpatient	2 ☐ ER/Ou	tpatient 3	DOA Oth	ner: 4 De Mursing Ho	me 5□Res	dence 6 Other	(Specify)	
C 2	5 00	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pendin	g (Mo gation	of Injury nth, Day 1	(Year) 28b. 7	Firme of njury M	28c. Injur Wor 1	y at rk? Yes 2 □ No	28d. Describe	how injury occurre	d	SI SI
Division and or Attending as after deeth.	led in by the funeral Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could	ined 288. Plet	e of Injunding, etc.	y - At home, fa (Specify)	rm, street, fac	tory, office			Street and Numbe wn, Stete)	r or Rural Route Nur	nber,
DIVISIO To the Hospital or Attendit within 24 hours after deeth.	completely filled in by the funer Medical Certification	29a. Certifier (Check only one)	1 Certifyin 2 Medical	Examiner: On the	e best of e basts of e nner stete	xaminetion and	, death occurred/or investigate	ed et the tir ion, in my o	me, date end place, ppinion, death occur	end due to the red at the time,	cause(s) end men date end ptece, ar	ner es stated. nd due to the cause(s)
Not with	Comic	29b. Signature and	title of certifie	ae M)			29c. Licens	-387	54	29d. Dete signed	(Month, Dey, Year) 7-99	
	8	30. Name and addre	ess of person	who completed cau	use of dea	th (Item 23a) (404	(Type, Print)	+STE	ERN B			-2122	-1 .
R	State egistrar	31. Date filed (Mont	1 8 199	19 Jan	Registrar	s Signardie	Spar	KN					



State of Maryland / Department of Health and Mental Hygiene 99

				Cer	tificate of	Death			Reg. No.		
Physician /Medical	Decedent's Name (First, Middle, EDWARD J. LIPT	ON						2. Data of De Month MAY	Day /3 /	Year 999	3. Time of Death 14: 06 PM
Examiner	4a Facility Nama (If not institution, ST A GN ES	HOSPIT	AL			BAU	TIM	or of Death			MORE
Funeral Director	5. Social Security Number 218-12-4204 Usual Residence of Decedent	Sex 7	. Aga <i>(In yrs.</i> 74	last birthday) Yrs.	Months Deys		24 Hrs. Min.	8. Data of Bird (Month, De JAN 31	y, Year)		place (State or Foreign ntry) RYLAND
t show led at Or	10a. Stata 10b. County	for E		y, Town or Loc							10d. Inside City Limits
or 28a-f show be notified at Director	10e. Street and Number	20112			10f. Zip Code				10g. Citizen of 1	What Cou	ntry?
Die Die		AVENUE				1228			U.S.A		
or terms 23a or 28a-f sho aminer.must be notified at y Funeral Director	11. Marital Status 1 Nevar Married 2 Married	12. Was Deced Armed Ford 1 X Yas 2	as? □No DIS	CH.	/as Decedent of Yas, specify Cut	Hispanic Ori pan, Mexicar		cify Yes or No Rican, etc.)		ce - Americk, White,	can Indian, etc.
LEXAL d by		Yaar or Dat	es: MAR 8	,1940						44 7 7 .	
disa disa	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give	ent's Usuat Occu kind of work done O NOT use retire	pation during mos	t of workin	9	16b. Kind of B	usiness/in	dustry
t, the Medical	Elementary/Secondery (0-12) 12TH GRADE	College (1-4	lor 5+)		ETTER CA				U.S. P	OSTA	L SERVICE
9 E 8	17. Fathar's Nama (First, Middla, La	ist)						(First, Middle, FRALKAS	Maiden Suman	ne)	
27 is ma or trauma	19a. Informant's Name/Relationship MARY R. DEBUS		4)		GAYLAWN						
Department of Health and Mental Important: If then 27 is marked o any injury or other traumatic avoides. To Be	20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremetion 3 4 🗀 Donation 5 🗆 Other (Spe		ere		ition (Nama of eatory or other pla DERAL CI		Y 5	Data / 17/99	20c. Location BALTIM		MARYLAND
hysician /Medical	23a. Part - Enter the disease, or conshock, or haert failura. List or immediate Ceuse (Final disease or condition	omplications that car only ona cause on each		HU 41	Name and Addr. IBBARD FT O7 WILK or the mode of dy	UNERAL ENS AV ing, such as	HOM!	-BALTIN	MORE, MA	ARYLA	ND 21229 Approximate Interval Between Onset and Death 30 MIN
ending physicien end ruse es the burial-transit	Cause (Disasse or injury that initiated events resulting in death) Last	o. CA	F Due to (o	r as a consequ r as a consequ r as a consequ	uence of):						YEARS YEARS
d by the atter- etached for u	Pert II. Other significant conditions	min .		ulting in the ur	derlying causa gi	iven in Part I	l.				to the cause of death?
requires that the		AILUI	25						100 1010	0000	, ,
0 0	BLADDER	2 mr	+ LIG	NA	NCY			24a. Was perio	an autopsy ermed?	an cx	fere autopsy findings vailable prior to ompletion of cause death?
e has t age 2 s								10	Yes 2000	1	☐Yes 2☐No
ician: The certificate h rector, page	25. Was case referred to medical					of Diag	of Dooth	(Check only		L	2010
s certificate hadirector, page	examinar? 1 ☐ Yes 2 No	Hospitel:	nationt 2	ER/Outpatien	3 DOA O	hor			dence 6 Ott	or /Spec	(K-1)
frer thi		28a. Data of (Month,	1	28b. Tima of Injury	28c. tnju		2		how injury occur		
ta for Attanding Present at Director: After fied in by the funers Certification:	2 Accident Invastigat 3 Suicide 6 Could no determine	be 28a. Place o	f Injury - At ho , atc. (Specify		et, factory, office			8f. Location (: City or To	Street and Numi wn, Stata)	ber or Rur	ral Route Number,
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Medical Certificati		Physician: To the beaminer: On the bas	is of axaminat	wledge, death ion and/or inv	occurred at the t astigation, in my	ima, data an opinion, daa	d place, a	nd due to the	cause(s) and m date and place,	anner as a	stated. to the cause(s)
Me Me	29b. Signeture and title of certifier		process.		29c. Licen	se number			29d. Data signe	d (Month,	, Day, Year)
≱ ⊢ δ	I true à	Bna	u		1	127	04		MAY	13	1999
	30. Name and address of person with ANNA KC	RZAN	90	20 C	970N	AVE		BALTI	MORE	MI	21229
State Registrar	31. Data filed (Month, Day, Year)	32. Jes	Istrar's Signa	G.	Sports	1					

DHMH 16 Rev 6/95

THE STATE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #20b,20c,per FH,G771,5/18/99dhb 5893 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year May 9, 1999 Michael N. Labausky 5:00 p.m. 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services **Baltimore** If Linder 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dala of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Hours Months 1 X M 2 □ F Yrs. 83 207-05-3403 Jan. 22. 1916 Scranton, PA Usual Residence of Decedant 10h County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yas 2 No Maryland Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Haslett Road 21085 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 Yas 2 No 1 Nevar Marriad 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 yrs. 3 yrs. Specialty Fabricator Anchor Fence Company 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Charles Lapausky Anna Koffel 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 415 Haslett Road Carol L. Metzger (Daughter) Joppatowne, Md. 21085 20e. Method of Disposition 20b. Place of Disposition (Nama of 20c. Location - City of Town Stata Dunmore, PA 18512 Dunmore Cemetery or other place) 15 15 13/99 1 X Burial 2 Cremation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Fallston, Maryland 21047 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility E.F. Lassahn Funeral Home, P.A. 11750 Belair Road Kingsville, Maryland 21087-1351 Minoc 23a. Part1. Entar the diseasa, or complications thet caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth tmmediate Cause (Final diseasa or condition rasulting in death) EXECULAR DISEASE Dua to (or as a consequence of): Sequentially list conditions, if any, leeding to immadiate cause. Entar Underlying

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

or Items 23s or 28s-f st aminer must be notified

Saltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records.

Pages 1 and 2 should be nent of Health and Mental Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic ev Directo

Funeral

À

Completed

Be

Examiner The law requires that the death certificate be executed Physician/Medical by Be Completed Hospital or Attending Physician: edical Certification: To After death. after death filled in by

Cause (Disaase or injury that initiated events rasulting in death) Last	c	Due to (or as a consequence	of):	7.110	IGA OSC LER	0515	TO CANUS.
Part II. Other significant condition	ons contrib	uting to death but not ras	sulting in the underlying	ng causa given i	n Part I.		use contribute to	the cause of death?
						24a. Was an autor performed?	ave cor of c	ara autopsy tindings all autopsy tindings all autopsy tindings all autopsy tindings are all at
25. Wes casa rafarred to medica	1			24	Place of De	1 ☐ Yas 2) eth (Check only ona)	2No 1	Yas 2□ No
axaminar? 1 Yas 2 No	Hosp	oital: 1 ☐ Inpatiant 2 ☐	ER/Outpatient 3□	Othor	4 Nursing F		6 □Othar (Specify	()
27. Mannar of Death 1 Natural 5 Pandir 2 Accidant invasti	19	28a. Dete of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injury at Work?	2 No	28d. Describe how injur	ny occurred	
3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide determ		28a. Place of Injury - At h building, atc. (Speci	oma, farm, street, fec	ctory, office		28f. Location (Street an City or Town, Stata	nd Number or Rura i)	l Routa Number,
29a. Certifiar (Check only one)	g Phyaicis Examiner:	n: To the best of my kno On the basis of examine and menner steted.	owledge, death occurration end/or invastigat	red at the tima, o tion, in my opinio	data and place on, deeth occu	e, end due to the cause(s) arred at the time, date and	and manner as st place, and due to	ated. the cause(s)

29c. License number

D-22609

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature end titla of certifian

31. Data filed (Month, D

within 24 hours a To the Funeral D

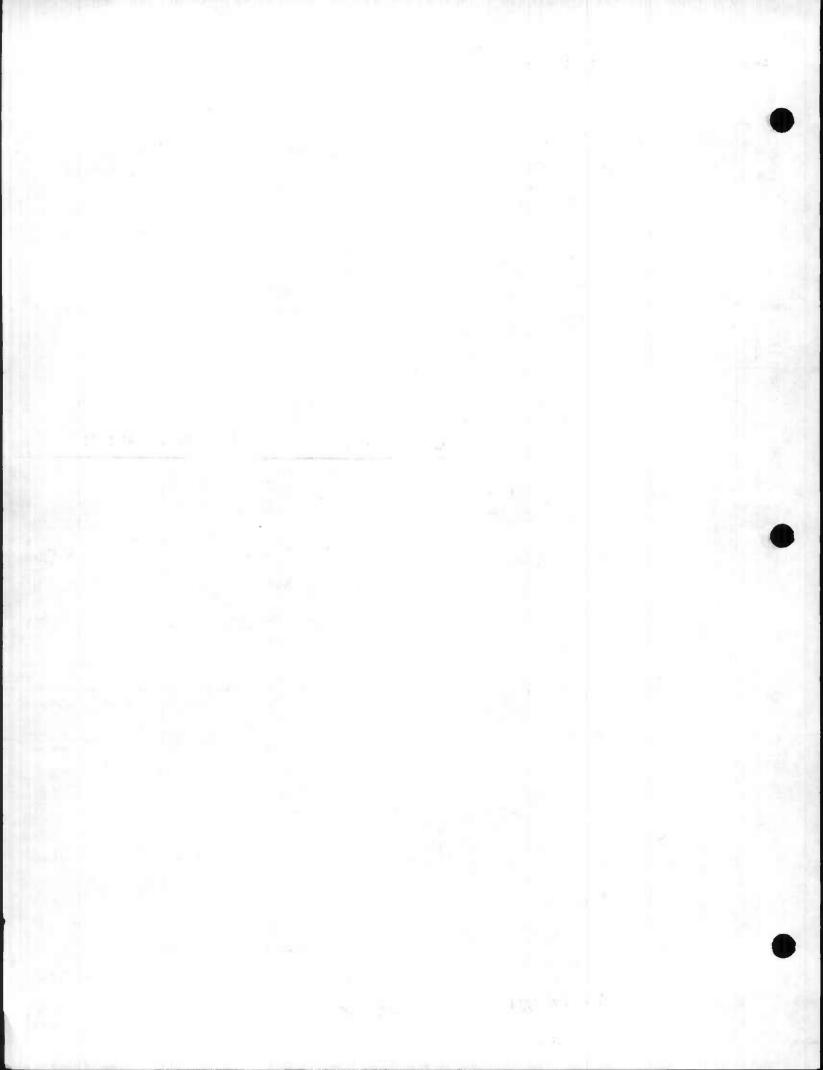
To the

BRANCH Rd 61e-Bune Hd 21060 7445 FURNACE 1999^{32. Registrar's Signatura}

M. A

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

REIDER



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** 1999 11:00PM MELVIN S. LASZCZYNSKI /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMORE N/A # Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Yes 5/3/27 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 72 Yrs. 217-20-1836 Director MARYLAND Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location LEYes 2 No Director N/A BALTIMORE MD 28a-f 96 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8 8 637 S. POTOMAC STREET U.S.A. 21224 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Yeer or Detes! 9 4 6 - 4 7 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status Black, White, etc. 72 hours after 1 ☐ Never Merried 2 ☑ Merried 21215-0020 8 1 Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) STANDARD OIL 10 0 CHAUFFER Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H sant: If Nem 27 is marked oth jury or other traumatic even Be THERESA BUCZKOWSKI JOHN LASZCZYNSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) MRS. LORRAINE LASZCZYNSKI 637 S. POTOMAC ST. BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from Stete DUNDALK, MD. 5/11/99 HOLY ROSARY CEME. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
KACZOROWSKI FUNERAL HOME P.A. 21. Signeture of Funeral Service Licenses Tacyorowshi 1201 DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last The law requires that the death certificate be axecu Box 68760. Physician/Medical Due to (or es a consequ 950 been signed by the atter should be detached for a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. o Thyroidism 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2ER/Outpatient 3 DOA this 27. Menner of Deet 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Accident 5 Pending investigation 24 hours after death.

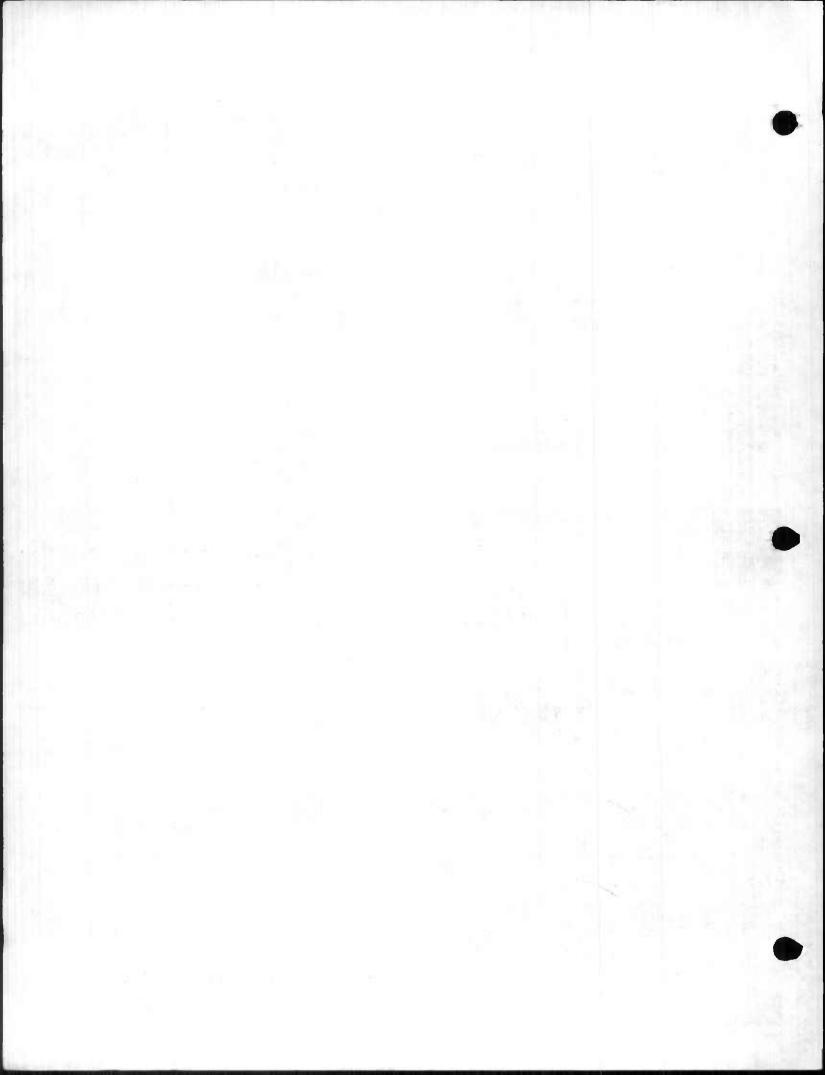
Funeral Director: A 1 Yes 2 No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menter: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stelled. 29a. Certifier (Check only one) To the Within 2 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 - NOCH RAVEN BIVA,

State Registrar

DHMH 16 Rav 6/95

32. Registrar's Signature

1999



State of Maryland / Department of Health and Mental Hygiene 99 ITEM: #23 PART I. PER MD G771 5-18-99 WR.

194-07-3894 86 Wis. Feb. 24, 1913 Masterial Residence of Decedant 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. City or Town, State 10c. City, Town or Location 10c. City or Town, State 10c. City, Town or Location 10c. City or Town, State	3. Tima of Daath
PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOLD Funeral Director 194-07-3894 Usual Residence of Decedant 10e. Stata 10b. County MD Wicomico Delmar 10c. City, Town or Location Delmar 10e. Streef and Number 30595 Gordy Mill Road 11. Marital Status 12. Was Dacedant Ever in U.S. Armed Forcas? 11. Never Married 2 Married 30595 Gordy Mill Road 12. Was Dacedant Ever in U.S. Armed Forcas? 11. Never Married 2 Married 30595 Gordy Mill Road 11. Never Married 2 Married 12. Was Dacedant Ever in U.S. Armed Forcas? 11. Yes 2 No Specify: 12. Was Dacedant's Education 13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Ricen, atc.) 15. Decedant's Education (Specify only highest grade complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Registered Nurse Hospital	
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MD Wicomico Delmar	10d. Insida City Limit
10. Street and Number 10. September 10.	
11. Marital Status	Country?
15. Decedant's Education (Specify only highest grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Registered Nurse 17. Fathar's Nama (First, Middla, Last) Charles Robinson 19e. Informent's Name/Ralationship (Type, Print) Lois Twilley/Step Daughter 20a. Method of Disposition 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifta. DO NOT usa ratired) 18b. Kind of Busine (Giva kind of work dona during most of working lifta. DO NOT usa ratired) 18b. Kind of Busine (Giva kind of work dona during most of working lifta. DO NOT usa ratired) 18c. Mothar's Name (First, Middla, Maldan Sumama) Eva Bradley Robinson 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State lifts) 20b. Placa of Disposition (Nama of cametary, cramatory or other placa) 20c. Location - City ametary, cramatory or other placa	marican Indian, Thita, atc. White
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20a. Method of Disposition 20b. Placa of Disposition (Nama of cametary, cramatory or other placa) 20c. Location - City	
4 December 5 Dother (County)	or Town, State
4 Donation 5 Other (Specify) Parsons Cemetery 4-27-99 Salisbur	y, MD
21. Signature of Funaral Sarvice Licensea 22. Name end Addrass of Fecility Short Funeral Home	
Molly Hanniagn 13 E. Grove St. Delmar, DE 19940	
23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) Due to (or as a consequence of):	Approximata Interval Between Onsat and Deeth
Sequantiatly list conditions, if any, laading to immadieta cause. Entar Underlying Causa (Disease or injury that thilletad avants rasulting in death) Lasf b. HYPERTENSION Dua to (or as a consequance of): SEPSIS Due to (or es e consequanca of): DM II	
Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3	
24a. Was an autopsy performed?	b. Wara autopsy findings evellebte prior to completion of causa of daath?
To be a control of the control of th	1 Yas 2 No
25. Was cesa rafarrad to medical exeminar? 1	
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2 Accident 3 Suicide 4 Homicide 28a. Place of thjury - At homa, farm, street, factory, office 28b. Location (Streat and Number of City or Town, Steta) 28c. Certifiar (Check only one) 29a. Certifiar (Check only one) 29b. Signature and title of certifiar 29c. Licanse number 29d. Date signed (M	
29b. Signature and title of certifiar 29c. Licanse number 29d. Date signed (M	as steted. due to the ceuse(s)

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State Registrar

A.DAVIS 31. Data fited (Month, Day, Year) APR 2 6 1999

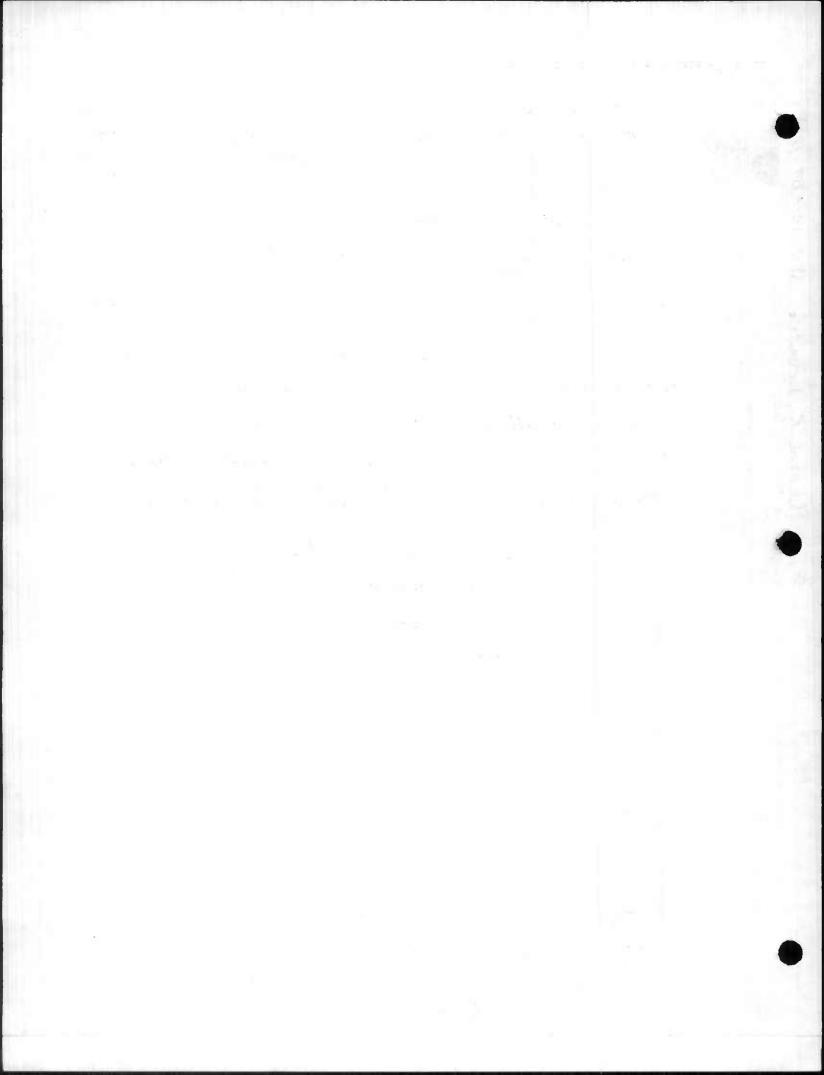


30. Nema and addrass of person who comptated cause of death (ttem 23e) (Type, Print)

MD

Delmer

D0054127



Decedent's Name ((First, Middle, Las	st)			-			2. Dete of De Month	ath Dey	Year	3. Tima of Death
Alexand				Lefko				May 7,	1999		11:18am
4a Facility Name (If n			er)					ocation of Death			
5. Social Security Num	mber 6. Se		Age (In yrs.	last birthday)	If Under 1	Year If	altimon Under 24 Hrs.	8. Date of Birt	th	N/A 9. Birthplac	ca (Stele or Foreig
220-05-58	000	M 2□ F	79	Yrs.	Months D	Deys H	lours Min.	Aug. 7,		Penns	ylvania
Usual Residence of D 10a. State 1	ecedent 10b. County		10c. CI	ty, Town or Loc	ation					10d	. Inside City Limits
Maryland	N/A			Baltim	ore						1 Nes 2 No
10e. Street and Numb					10f. Zip Co	ode			10g. Citizen of V	Whet Country	17
2902 Westf	ield Ave					1214				ed Sta	
11. Marital Status 1 Never Married 3 Widowed 4	1927	12. Was Deceder Armed Force XXYes 2[If Yes, Give Year or Deter	No J.H.I T		las Deceden Yes, specify Yes 212		nlc Origin? (Sp lexican, Puerto pecify:	pecify Yes or No Rican, etc.)	Specify	e - American ck, White, etc v: Whit	
	5. Decedent's Edit only highest grad			16a. Decede	ent's Usuel C	occupation	n ng most of work	cina.	16b. Kind of Bu	usiness/Indus	stry
Elementary/Second		College (1-4c	vr 5+)	life. D	O NOT use r	retired)				mental	
17. Father's Name (Fit	irst Middle Last)			LIT	e Inst		e Agen		Insu Maiden Sumerr		Company
	efko							Warholik		-1	
19a. Informant's Nam		ype, Print)		19b. Mailing	Address (S				er, City or Town,	Stele, Zip C	ode)
Anna Mar		e / Dau	ghter		Murdoo		ad Ba		MD 212		
20a. Method of Dispos 1 X Burial 2 0		Removal from Sta	te	Plece of Dispos cemetery, crem	etory or othe	r plece)		Dete	20c. Location -		
4 ☐ Donation 5	Other (Specify,)	St.								Maryland
21. Signature of Fune	Tuy S.	Haur		530	5 Harf	ford	Road I	Baltimor	al Home e, MD 2	1214	
23a. Pert1. Enter the shock, or heart f	disease, or comp lailure. List only o	lications thet caus one cause on each	ed the dee	th. Do not ente	r the mode o	of dying, so	uch es cardiac	or respiratory a	rrest,	In C	pproximate itervel Between Inset and Death
Immediate Cause (Fir	nel		Art	to Cara	1: 1	1/.					/-
disease or condition resulting in death)		a		or as e consequ		oull	re			1/1	one
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that initiated events resulting in death) Las	st	d	Due to (d	er es e consequ	ence of):						
Doe it Other classifica			h . A = A	411-44	4. 4. 4		Death	90h DI4			
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STEP STE	PE							24a. Wes	en autopsy rmed?	evaile	autopsy findings able prior to bletion of cause ath?
								10	Yes 2 No	101	res 2□ No
		Hospitat:				26 Other:	. Plece of Dee	th (Check only o	one)		
25. Was case referred examiner?)	28a. Date of Ir		28b. Time of Injury	-	Injury et Work?	4 □ Nursing H		dence 6 Oth		
examiner? 12(Yes 2 No 27. Manner of Death 12(Vatural	5 Pending investigation		niun, At h	ome, ferm, stre	et, fectory, of	ffica		28f. Location (City or Tox	Street and Numb vn, State)	ber of Rural F	Route Number,
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State of Maryland / Department of Health and Mental Hygiene

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			e street and numbe				4b. City, To	wn, or Location	n of Death	4c. County	of Death		
	4800 B	rock ord	YORK RD.				BALT	IMORE		N,	/ A		
al 5. S	ocial Security Nu			Age (In yrs. last b		If Under 1 Year Months Days		24 Hrs. 8. D Min.	ate of Birth Wonth, Day,	Year)	9. Birthp	place (State or Fo	reign
	9-99-3	199	2 F	2	Yrs.				3 17			ryland	
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											,	XM Yes 2	
0	id.	N/A		Balt	ımor	e City							7140
100	. Street and Numl	ber				10f. Zip Code			1	0g. Citizen of V	What Coun	itry?	
	26 Ell	icott I	Prive			2121	6			U.S.A	Α.		
Funeral	Marital Status		12. Was Deceder Armed Forces	nt Evar in U,S.	13. W	as Decedent of I Yas, specify Cub	Hispanic Original	gin? (Specify)	Yas or No-		e - Americ	an Indian, etc.	
	1 Never Married		1 ☐ Yes 2X If Yes, Give			□Yas 2□XNo					Bl.		
	3 ☐ Widowed 4	Divorced	Year or Dates	3;									
e e	(Specify	Decedent's English only highest gra	ducation (de completed)	168	. Decede (Give ki	nt's Usual Occup ind of work done O NOT use retire	pation during most	t of working		16b. Kind of Bu	usiness/ind	dustry	
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	i, Informant's Nan					Address (Street							
			ls, Sr/F				ott I						16
20a.	Method of Dispo		Removal from Stat	cemete	or Disposi ery, crema	tion (Name of atory or other pla	ice)	Da	ite :	20c. Location -	City or To	wn, Stata	
	4 Donation 5				Mem	orial	Park	15/2	20/99	Wood	Lawn	. Md.	
21.	Signature of Fund	eral Service Licer	isee / /		22.	Name and Addre	ess of Facility	y					
,	Darl	4116 5	11. 11/10	m-	WI	111am	C. Bi	rown (commu	nity I	'une	ral Hor	
236	Part 1. Enter the	disease, or com	plications that caus	ed the death. Do	not enter	the mode of dyi	ng, such as	cardiac or res	piratory arre	Baltin est,	nore	Approximete	212
	Shock, or near	tallure. List only	one cause on each	ine.		,						Interval Betwee Onset end Deel	th
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Physician/	II Other signific	ant conditions o	ontributing to death	but not resulting	in the use	lerlying cause ==	ven in Dart I	- 1	23h Did to	hacco use co	ntribute to	o the cause of de	eath?
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Completed									perform	ned?	av.	allable prior to impletion of caus	
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5 27.	Manner of Deeth I □Natural	5 Pending	28a. Dete of In		Time of Injury	28c. Inju Wo			Describe ho	w injury occur	red	P	
Cat	2 Accident	invastigation	0/(3/	99 2	747		Yes 201		1001	ecs	& Fe	N	
=	3 Suicida Homicide	determined	208. PIECE OT I	njury - At home, f etc. (Specify)	arm, stree	et, factory office		28f. L	ocation (St City or Town	reet and Numb , State)	per or Rura	al Routa Number,	
Certification:				577	RETE	テーノン	TUTO) 4	100 B	1K. 010	1 60-	K 140.	
	Certifier 1	☐ Certifying Ph	ysician: To the bes	of examination	e, death o	occurred at the ti	me, date an	d place, and d	lue to the ca	ause(s) and ma	anner as s	tated.	
	one)	Manual Evall	and manner s	stated.	WOI IIVO	ougation, in my (opinon, deal	av occurred at	are time, O	are and place,	9110 008 (0	, are ceuse(s)	1-
≥ 29b.	Signature and tit	te of certifiar	1 0	^		29c. Licens				9d. Date signe			
	1/1/	R1n	Lorlo	Dan		0.0	.M.E			MAY 14,	, 1999		
30.1	Vame and address	s of person who	completed cause of	deeth (Item 23a)	(Type P	rint)							
	TLAR	MIL	CKE, MA	()	4.3E-41.		n Str	eet. Ba	altimo	re. Man	rylan	d 21201	
ato 31.	Date filed (Month,	Day, Year)	32. Regis	trar's Signature				-,		,	7		
State Strar	MAY	1 8 1999	Bu	war	4	1							
			100		. /	Mar . A							

DHMH 16 Rev 6/95

Sports

YARWANIK HYWWY 1206 W. North Avenue, Baltimore, Md. 2121

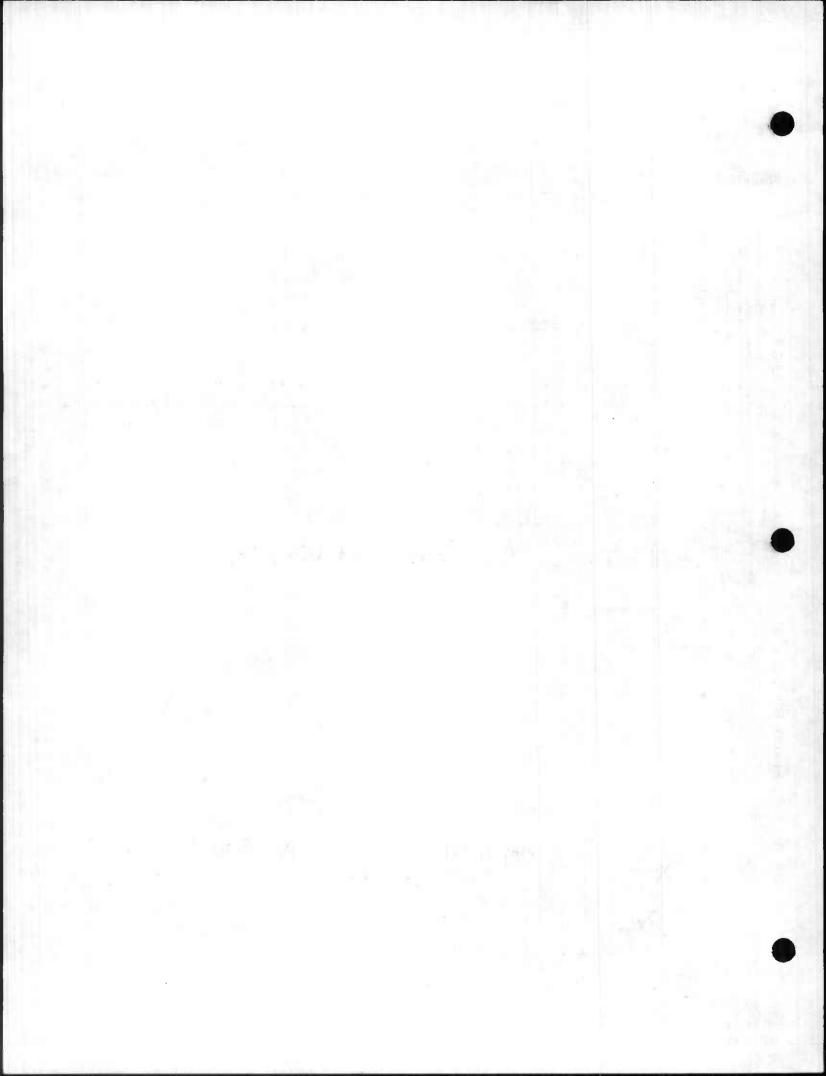
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State of Maryland / Department of Health and Mental Hygie

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-2090-210				Cer	tificate	of L	Death			Reg. No.)	13030
	1. Decedent's Name (First, Mi			25%	10				2. Dete of De Month		Yeer	3. Tima of Death
Physician /Medical	Sylvester	Logan							MAY		999	0359 AM
Examiner	4a Facility Name (If not institu	tion, give street and nur	mber)			4	b. City, To	wn, or Lo	cation of Deat	4c. Count	y of Death	
	UNIVERSITY SH	+					BALTI					
Funeral	5. Social Security Number 215-82-9680	6. Sex 1√2 M 2□ F	7. Age (In yrs. last 23	t birthday) Yrs.	Months [Year Days	If Under a	Min.	8. Dete of Bir (Month, Da	th ly. Year) 1975	9. Birth	place (State or Foreign ntry)
Director	Usual Residence of Decedent	X	23	25 119.				May 26, 1975 Baltimor			ltimore, MD	
should be filed within 72 hours efter deeth with the Maryland and Mental hygiens. marked other than "retural", or ferms 23s or 28s-f show unracte event, the Medical Eseminar must be notified at To Be Completed by Funeral Director.	10a. State 10b. Cou	nty		Town or Loc								10d. Inside City Limits
28a-1 ahow notified a	MD 1	n/a	Ba	Baltimore							1 X Yes 2 □ No	
or 28s-f all be nonfred Director	10e. Street and Number			10f. Zip Code					10g. Citizen of Whet Country?			
Sa Ca	855 Harlem A	venue		21201				Unite	d Sta	ates		
r flores 234 diose mant Funeral	11. Marital Status	12. Wes Dece Armed Fo	edent Ever in U,S.	in U,S. 13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto R				city Yes or No	- 14. Ra	ce - Ameri	can Indian,	
by by	1 Never Married 2 Nover Nation 1 Nover Married 2 Nover Nation 1 N	lerried 1 Tes	2 No	1 ☐ Yes 2 ☐ No Specify:				mount, otto.)			ck American	
Vental Hygiene. riked other than "natural", title event, the Medical Ex- TO Be Completed by	15. Decedent's Education (Specify only highest grade completed)			16a. Deced	lent's Usual (Occupe done d	ntion Jurina most	t of workii	10	16b. Kind of B	Business/In	ndustry
in dr	Elementary/Secondary (0-12) College (1-4or 5+)				kind of work	retired)					
S S	17. Father's Name (First, Middle, Last)			Chef 18. Mother's Name (First, M					44.14.0		staurant	
2 0	Sylvester Wil								(First, Middle Jogan	, Maiden Sume	me)	
T the	19a. Informant's Name/Relation			405 44-00-	a Address (f	Name 1 .				na Citu na Tour	- Ctoto 7	- Codel
Mary land of 2 should be file th and Mental Hy 27 is marked other fraumatic event To Be C	Beulah Logan		19b. Meiling Address (Street and Number or Rural Route No. 855 Harlem Avenue, Baltim									
om 2	20a. Method of Disposition	20b. Plac		sition (Name netory or other				Dete	20c. Location			
permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hyglens. Important: if item 27 is marked other than any injury or other traumatic event, the Mannes. To Be Compi	DEVOUNDE 2 22 CHARGOOT 3 ELEMENTON STATE											
	21. Signature of Funeral Servi	Loud	1 38	ark Ce				/15/99	99 Baltimore, MD			
	21. Signature of Funeral Sarvige Liperistics 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229											s Avenue
	23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
ysician ledical	Insuration Cours (Final	0	1	1	1	1			1	Onset and Death		
aminer	Immediate Cause (Final disease or condition resulting in death)	. ///	Utible	GUM	Isho		Wou	Ind	5			
			Duerto (or as	s a conseq	uence of):						- 4	
n and fai-transit Examiner		ø b									- 1	
Na in	Sequentially list conditions, if any, leading to immediate		Due to (or as	s a consequ	uence of):						- 1	
	cause. Enter Underlying Cause (Disease or injury that initiated events		to (or as a consequence of):									
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y P								10	1□ Yes 2 No 3□ Probably 4			
artificate has been signed by the strendinotor, page 2 should be desirched for use Be Completed by Physician/A	T 4 45 5 1								24a. Was	an autopsy	24b. W	Vere autopsy findings
ato at									perfe	ormed?	0	vallable prior to ompletion of cause f death?
page 2									74		3	1
8 0	25. Was case referred to med	test I				_				Yes 2□No	,	Yes 20 No
and and	examiner? XXYes 2 No	Hospital			-01	Othe	ar.		(Check only			
To To	27, Manner of Death	28a. Date o		VOutpatient Nb. Time of	3EXDOA		4LFNu			dence 6 00 hew injury occi		(9)
for the	1 □Natural 5 □Pen	OR Broads	h, Day Year)	3:20		Work		No.	Sillia	4	sh	+
Iffice	3∏ Suicide 6 ☐ Cou	id not be	of Injury - At home	And in contrast of	T				28f. Location			
ert er	4) Homicide Gens	ermined 286. Place buildir	ng, etc. (Specify)	1-	1	-			City or To	wn, Stete) 80	O bloc	ral Route Number, K Harlein Ave
0	29a. Certifier 1 Certif	ying Physician: To the	heet of my knowle	ST(the tim	no data an	d place 4	and due to the	course(s) and s	000001 00	21217
completely filled in by the funer Medical Certification:	(Check only XX Medic	ying Physician: To the cal Examiner: On the be and man	asis of examination	and/or inv	restigation, in	my of	pinion, deal	th occurre	ed at the time,	date end place	, and due	to the cause(s)
M M	29b. Signature and title of cert	- 1					e number			29d. Date sign		
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6	2000	" Cucha	JV VY	0-\ CT : :	D						1 +	
1	30. Name and address of pers	on who completed caus					D-31			-land 2	1201	
Chata	31. Date filed (Month, Day, Ye	TO TO	egistrer's Signetur		stree	et,	Balt	пюг	e, mary	rland 2	1201	
State Registrar	MAY 1 8 1999	h. Se. N	-									
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Certificate of De	eath	Reg. No. 99	15899
Physician	1. Decedent's Name (First, Middle, La			2. Date of De Month		3. Time of Death
/Medical _	Naomi Catherine			MAY	10 1999	12:45 pm
Examiner 4	la. Facility Neme (If not institution, giv		4b. (City, Town, or Location of Deeth	4c. County of Death	
	Charlestown Nurs			Baltimore	Baltimor	
ector	370 40 1033	7. Age (<i>lin yrs. la</i> : 1□ M 2 1□ F 90		Hours Min. 8. Date of Bird (Month, De May 7,	h 9. Birthp <i>C</i> our 1909 Ma	place (Stete or Foreign http) ryland
	Jsual Residence of Decedent 10a. State 10b. County	10c City	Town or Location		Ι,	IOd Incide City I leads
Director	MD Baltimo		consville			10d. Inside City Limits X☐ Yes 2☐ No
event, the Medical Examiner must be notified at Be Completed by Funeral Director	10e. Street and Number 707 Maiden Choi	ce Lane; #9T04	10f. Zip Code 21228		10g. Citizen of What Cour United Sta	*
by Funeral	Marital Status Never Married 2 Married Midowed 4 Divorced	12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	13. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Specify Yes or No Mexicen, Puerto Ricen, etc.) Specify:	Black, White,	
eted a	15. Decedent's Ed (Specify only highest gre	ducation	16a. Decedent's Usual Occupatio	n nament of working	16b. Kind of Business/Inc	dustry
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)	(Give kind of work done duri life, DO NOT use retired)	ng most of working		
Con	12	0	homemaker		home	
e 1	7. Father's Name (First, Middle, Last)		18	. Mother's Name (First, Middle,		
2	Omar Bennett Bro	10		Nora Evaline		
	19e. Informant's Name/Relationship (Rev. Dr. William		19b. Mailing Address (Street end			
				ear Drive, Will		
9500	Oa. Method of Disposition 1 ☑ Burlel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removal from State	ce of Disposition (Name of letery, cremetory or other place) Win Mem. UM Cem	netery 5/14/99	20c. Location - City or To	
aouce.	21. Signature of Funerel Service Lig	800/ / 1	22. Name end Address of			
8	10mg -1	480 Unn	Loudon Park Baltimore, M	Funeral Home, faryland 21229	3620 Wilkens	s Avenue
(Part Enter the disease, or com	plications that caused the death.	Do not enter the mode of dylng, s			Approximete
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ner						
edical Examiner	Sequentially list conditions,	Due to (or a	s a consequence of):			
	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
Medical	het initiated events esulting in death) Last	C. Due to (or a	s e consequence of):			
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and		d			i	
y Physician/	art II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying cause given is	n Part I. 23b. Did t	obacco use contribute to	the cause of death?
by Physician/	Pneumonia			101	>-	bably 4 Unknown
leted					rmed? ava	ere autopsy findings allable prior to mpletion of cause
Comp					V	death?
	5. Was case referred to medical			101		Yes 2 No
	exeminer?	Hospital:	Othor	3. Place of Deeth (Check only o		
O 2	7. Manner of Deeth	1 □ Inpatient 2 □ EF	VOutpatient 3LI DOA	4 Nursing Home 5 Resid	dence 6 Other (Specify now injury occurred	y)
Certification:	1 Natural 5 Pending Investigation	(Month, Dey Year)	Injury Work? M 1 ☐ Yes	2 🗆 No		1.75
Medical Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (5 City or Tow	Street end Number or Rura n, State)	I Route Number,
edical	9e. Certifier (Check only one) 1 Certifying Phy	ysician: To the best of my knowle ilner: On the basis of examination and manner stated.	dge, death occurred et the time, of and/or investigation, in my opinio	dete and place, and due to the con, death occurred at the time,	ause(s) and manner as st dete end piace, and due to	tated. the cause(s)
2 2	9b. Signature and title of certifier	/ // /	29c. License nu	mber	29d. Date signed (Month, I	Dev. Year)
	(Sen) J	troford	D 20	6473	MAT 11,	
30	DERNARD PROBLEM	completed cause of deeth (Item 23	Be) (Type, Print) ENCHACE LAN	UE DALTIF	IORG, MO.	21228
State 3	1. Date filed (Month Pen Year) 100	32. Pegistrar's Signatur	6 /			

State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 14, 1999 10:50 PM Harry Leslie Marriott 4e Fscility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F 213-28-0240 69 Yrs. APR 22, 1930 Maryland Usuai Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limita 1 ¥Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3710 Springwood Avenue 21206 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Yeer or Detes: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yea 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Marcella George Holmes Marriott 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Dorothy E. Marriott/wife 3701 Springwood Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 05/15/99 Baltimore, MD 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. MacNabb George E. 299 Frederick Road Baltimore, 21228 MD. 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth ASPIRATION PNEUMONIA 2 DAYS Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): UROSEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequenca of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Waa an autopsy performed? DIABETES MELLITUS 1 Yea 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Department of Important: If any Injury or Drice.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or Nems 23s or 28s-f show trsumstic event, the Medical Examples must be northed all

filed within 72 hours after thygiene.

Pages 1 and 2 should be file ment of Health and Mental Hant: If item 27 is marked oth jury or other trsumatic even

Baltimore, Maryland 21215-0020

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Examiner Physician/Medical

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1 Naturet 2 Accident

3 Suicide

4 Homicide

(Check only one)

5 Pending

investigation 6 Could not be determined

Division of Vital Records, P.O. or Attending after death. Director: Ah

Certification: 24 hours a Funeral D edical 29a. Certifier completaly To the To the To the F 29b. Signature and title of certifier

> State Registrar

mella mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D 41410

1 ☐ Yea 2 ☐ No

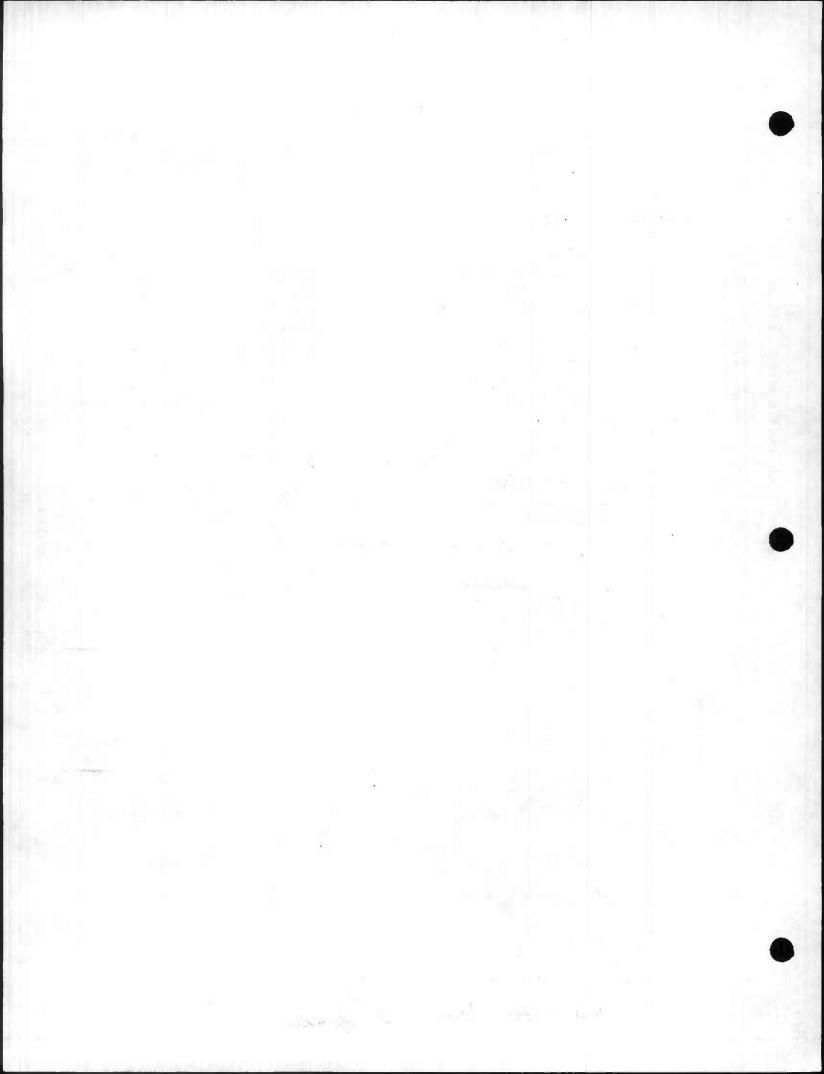
to Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, end due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

JOGINDER P. MEHTA, M.D., 7601 OSLER DRIVE, TOWSON, MD 21204

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



MEKO McCOY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician	1. Decedent's Nama (First, Middla, La: Meko Bjorn	Certificate of		2. Data of Dec Month	ith Day	Year 3. 1	ima of Death			
/Medical		McCoy			dh Ohr Taum and	MAY			1:36 A	
Examiner	4a Facility Nama (If not institution, given ST. JOSEPHS H	· ·			4b. City, Town, or L TOWSON	ocation of Death	4c. County			
uneral rector	214-31-3490	ex 7. Age	(In yrs. last birt	hday) If Under 1 Yaar Months Days	If Under 24 Hrs.	8. Data of Birt Month, Da 10/05/	h		Stata or Foreign	
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be nothing at Director	10e. Street and Number			10f. Zip Coda			10g. Citizen of V	Vhat Country?		
ral [8719 Loch Bend Dr					21234		Α.		
al, or form 23a or 28a-f a Examiner must be notified by Funeral Director	11. Marital Status Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent El Armed Forcas? 1 Yas 22 No If Yas, Giva Year or Datas:		ar in U,S. 13. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Maxican, Puar 1 Yas 2 No Specify:				e - Amarican Ind k, Whita, atc. - Black	lian,	
dical	15. Decedent's Ed (Specify only highast gra		16a.	Decedent's Usual Occup (Give kind of work dona	nt's Usual Occupation nd of work dona during most of working O NOT use ratired)			siness/Industry		
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To B	David		McC	Coy	Sandy			Byers		
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Department of Health Important: If item 27 any injury or other th DRGB.	Sandy McCoy / Mot 20a. Mathod of Disposition	her	otion and a second	8719 Loch Bend Dr.; A			APT 145, Baltimore, MD 2			
	1 ☐ Burial 2 ☐ Cremation 3 ☐		cemeter	cemetery, crematory or other place)			5/20/99 Catonsville, MD			
	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Sanda Licen		Metro	Crematory, Nama and Addre	Inc.					
Puy DDC	1/1/			8521 Loch	1116	e Johnso				
dical dical niner	Immediate Causa (Final disaesa or condition rasulting in daath) a. CARDIORESPIRATORY ARREST Due to (or as a consequence of): PULMONARY HYPERPLASIA (VENTILATOR DEPENDENT)									
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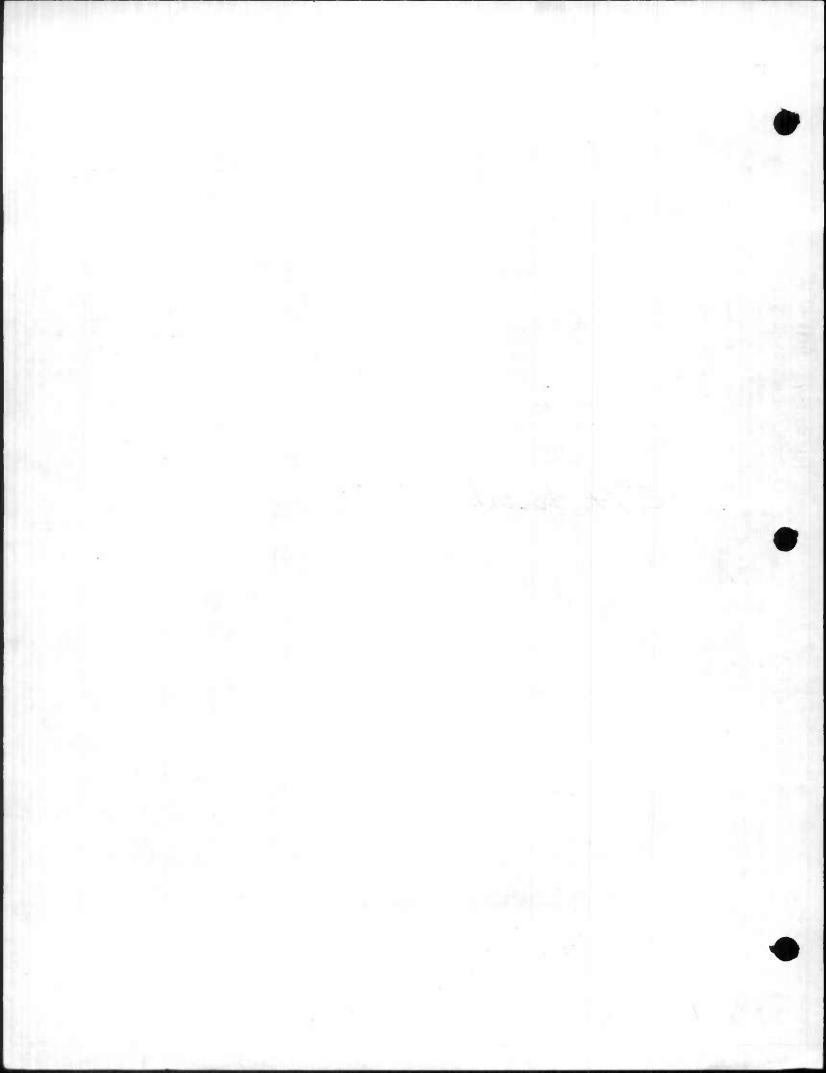
ITEMS: #5,	6,7, 8, 9 PER F.H. G77	State of Marylan 1 5-18-99 WR.		rtment of F			giene 9 9		5902	
Physician	1. Decedent's Name (First, Middle, Las	0)	A A	0		2. Data of De Month	ath Day	Year	3. Time of Death	
Physician /Medical	AUDREY		MII	LER		May	5 199	9	12:35AM	
Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or Lo		,		1,200	
Function	11801 Cedar La 5. Social Security Number 6. Se		last birthday)	If Under 1 Year	Kingsvil MrUnder 24 Hrs.		Balti			
Funeral Director		□M 210 F 82	Yrs.	Months Days	Hours Min.	8. Data of Bird (Month, Da 08-25-1			lace (State or Foraign try) VILLE. MD.	
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with the Maryland a or 28a-1 show be notified at Director	Maryland Baltimore			aguori				1	0d. Insida City Limits 1 ☐ Yes 2 🕅 No	
or 28s-4 s be notified Director	10e. Street and Number	e King	sville	10f. Zip Code			10g. Citizen of W	hat Coun	trv?	
Sa over state or stat	11801 Cedar Lane			21087		U.S.A.				
other death w	11. Marital Status	12. Was Decedent Evar in U,	,S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yas or No			an Indian,	
on after	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give		Yes 2 No	Specify:	riouri, ato.,	Specify:	llack, Whita, atc.		
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Ind 21215-0 be filed within 72 to all hygiens. d other than "natur went, the Medical. Be Completed	(Specify only highest grad	le completed)	(Give I	kind of work done OO NOT use retired	during most of work d)	ing	Baltimo			
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D STATE OF THE PARTY OF THE PAR	17. Father's Nama (First, Middle, Last)				18. Mothar's Name	ma (First, Middle, Maiden Sumame)				
Maryland 3.2 should be fise h and Mental Hy if is marked othe returnable event TO Be	George Thomas Kuhi				Cora Cru					
M d 2 st d d 2 st d d d 2 st d d d d d d d d d d d d d d d d d d	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Carol Kuchta (Daughter) 47 Dendrow Ct. Baltimore, Md. 21234									
re, N s 1 and t Health tem 27 other tr	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of		Data	20c. Location - 0		wn, Stata	
altimore, mit. Pepes 1 ar partment of Hea portent: if Item. y Injury or othe 28.	1 D Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Hemoval from Stata		emorial G		5/8/99	RelAir	Mary	/land 21014	
alt.	21. Signature of Funeral Service Licens		22.	Nama and Addra	ss of Facility		DOI/III,	1101	71010 21014	
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	23a. Part1. Enter the disease, or comb shock, or heart failure. List on 10	lications that caused tha death	n. Do not ente	or tha mode of dyir	ng, such as cardiac	or raspiratory a	rast,	y Lai	Approximata Intarval Between	
Physician /Medical								1	Onset and Death	
Examiner	Immediata Causa (Final disease or condition resulting in death)	. MULTI			OMA			1	10 mantes	
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n and lateransit	Sequentially list conditions,	b. — Due to (or	r as a consequ	uence of):		174		1		
9760, sate be assected bhysician and the butal-transit dical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.									
S8760, cate be a physician the burie	that initialed events resulting in death) Last Dua to (or as a consequence of):									
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P.O. BOX 63 telt the death certific d by the attending pletached for use as: Physician/Mec	Part II. Other significant conditions co	ntributing to death but not recu	ulting in the up	dodrina cauca air	en in Part I	23b. Did tobacco use contribute to the cause of death?				
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The law requires the law requires the law been signed, page 2 should be Completed by							an autopsy med?	ave	ara autopsy findings allable prior to mpletion of causa	
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Of VItal Physician: T this certificat rai director, p	25. Was casa refarred to medical axaminer? 1 Yas 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Oth	26. Place of Deat		<i>ina)</i> Jence 6 ⊟Otha	e (Casaih		
VISION OF VITA Attanding Physicien: or death. ector: After this certific by the funeral director, liftcation: To Be (27. Manner of Death	28a. Data of Injury	28b. Tima of	28c. Injur			now injury occurre		"	
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DIVISION C but or Attanding P is after death. at Director: After led in by the funera Certification:	3 Suicide 6 Could not be detarmined	28e. Place of Injury - At ho building, atc. (Specify	oma, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numbern, State)	or or Rura	l Route Number,	
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DIV To the Hospital or A within 24 hours after To the Funeral Dire completaly filled in b Medical Certi	29a, Certifier 1 Noertifying Phy (Check only one)	sician: To the best of my knowner: On the basis of axaminat and manner stated.	wledge, death tion and/or inv	occurred at the tire estigation, in my o	na, data and place, pinion, death occurr	and dua to tha ed at the time,	cause(s) and mai data and place, a	nnar as st nd dua to	ated. tha cause(s)	
within 2 To the comple	29b. Signature and titla of certifier	and memor states.		29c. Licens	e number		29d. Date signed	(Month,	Day, Year)	
- > - 0	Clarke Post	rettur		D	15546		May (0,1	999	
	30. Name and address of person who ex	ompleted cause of death (Item	23a) (Type F	Print)		7	201		A	
	Charles Pado	ett, MD, 5	6011	och k	aven 15	lud,	Soltin	lore	MD 2(239	
State	31. Data filed (Month, Day, Year)	32. Registrar's Signal	tura /	1					1.0	
Registrar	MAY 181	999 June	D.	span	6					

DHMH 16 Rev 6/95

MILLER

AUDREY

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS #17 & #18 PER FH G776 10/20/99 AH 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician ebron auletta ason 00 AN MA /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner - Mercy Maris Daltomore
if Under 24 Hrs. 8. Dete If Under 1 Year 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 KF Months Deys Hours Min. Yrs. 2-16-72-5386 Director Usuel Residence of Decedent with the Marylend 10d. inside City Limits 10a. Sfete 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahos other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Director NA Daltimore 10e. Sfreet end Number 10f. Zip Code 10g. Citizen of What Country? -ond 21229 Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Bleck, White, etc. nit. Pages 1 end 2 should be filed within 72 hours after lartment of health end Mental hygiene. ortant: If item 27 is marked other than "natural; or ite injury or other traumate avent, the House I savring. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify p 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation UVIL (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12th grade NA 18 Mother's Name (First, Middle, Maiden Surneme), ROSA LEE MARYLAND 17. Fether's Neme (First, Middle, Last) Be FAISON SHAW 19a. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) undalk, md Road shtord Daughter 20 eresa eu. 21222 20b. Piece of Disposition (Neme of cemetery, cremetory or other p 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Cenetery 5-22-99 22 Name and Address of Feci Parch F. H. W. 21. Signefure of Funeral Service Licenses Walnesh Suenue 21215 300 4 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete fritervei Between Onsef end Death **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Carre Nonth Examiner Due to (or es e consequenca of): Examiner physician and s the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 88 esn. Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 2 No 3 Probably 4 Unknown signed by þ 8 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? page 2 s certificate has 1 ☐ Yes 2 ☐ No MASS. HMETCH or Attanding Physician: Be 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Other (Specify N) Smy 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residenca Certification: To 1 Inpatient After this funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28a. Dete of injury (Month, Dey Year) 28c. injury et Work? 1 Neturel 2 Accident 5 Pending investigation 24 hours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Piece of injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and maintain as section.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. Medical To the Hosp To the Fune completely f (Check only one)

29c. License number

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St Pne Pl

29d. Date signed (Month, Day, Year)

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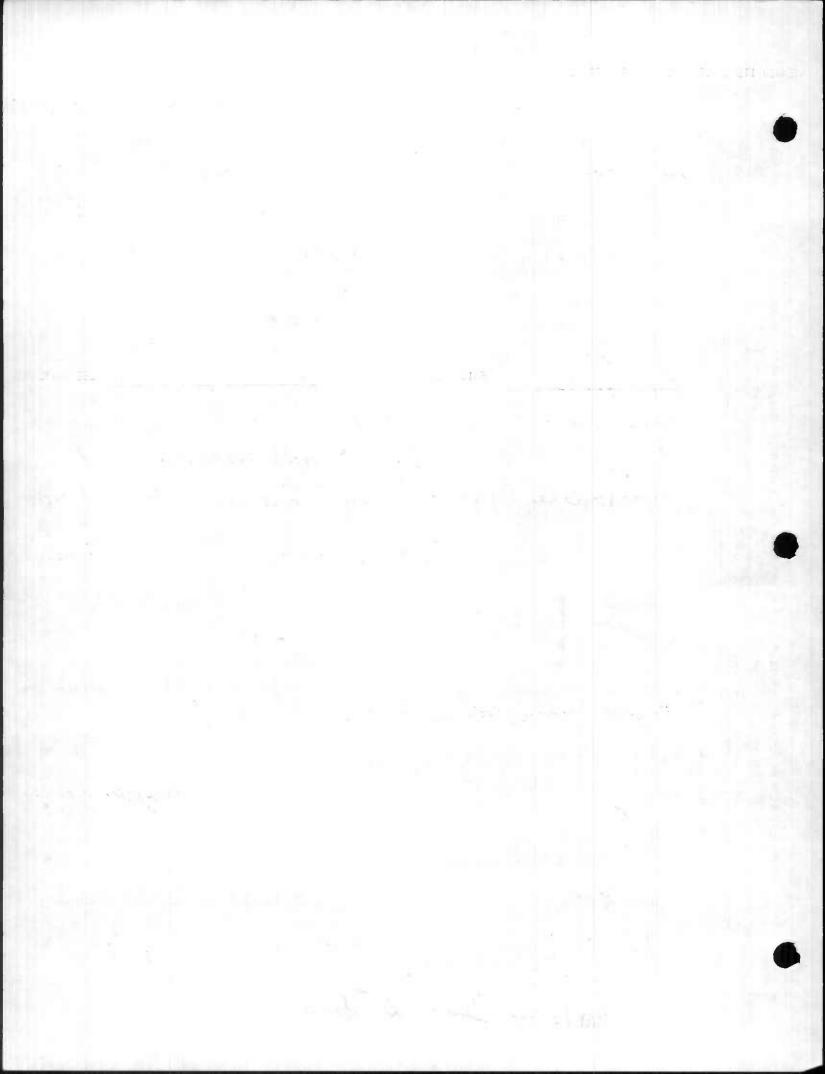
Registrar

29b. Signature end title of certifier

31. Dete filed (Month, Day, Yeer)

30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print)

32. Registran's Signeture



WRC 99-2652-510 Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. PATRICIA A. State of Maryland / Department of Health and Mental Hygiene MELTON (UNK 99-098) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Patricia Ann Melton 1999 MAY 09, 3:35 PM. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4802 REISTERSTOWN RD. BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2ØF 218-90-3144 26 Md Director Usual Residence of Decedent 10b. County 10c. City, Town or Location - NOUS 10d. Inside City Limita rail, or frame 23s or 28s-f shore Examiner must be northed at Director NA 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 Burford Court 21207 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2/☐ No If Yes, Give natural, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 10th grade College (1-4or 5+) Retail Stores NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) parmit. Pages 1 and 2 should be filt Department of Health and Mental th Important: If Item 27 is marked oth eny Injury or other treumatic even page. Be William F. Melton, Sr Juanita Cornwell 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Melton, Sr Father 2805 Silver Hill Avenue Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 Cremetion 3 Removal from State King Memorial Park 5-18-99 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H We West lad 4300 Wabash Avenue Baltimore, Md Warre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 980 P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, py 24b. Ware autopsy findings available prior to Be Completed 24a. Was an eutopsy performed? completion of cause of death? 2□ No 1 Yes 2□ No certificata of Vital after death.

Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) AT Other: 4 Nursing Home 5 Residence 6 Diother (Specify) Medical Certification: To 1⊠ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral SCENE 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division 1 Netural 5 Pending xct She7 1 Yes 2 No Found 5/9/98 investigation 2 Accident 1530 KR 281. Location (Street and Number or Rural Route Number. City or Town, State) 4902 Restriction 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide dwelly To the Hospital of the Tuneral Discompletely filled i Mary lag 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, if my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certitier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10, 1999 MAY O.C.M.E.

State Registrar THEODORE

31. Date filed (Month, Day, Year)

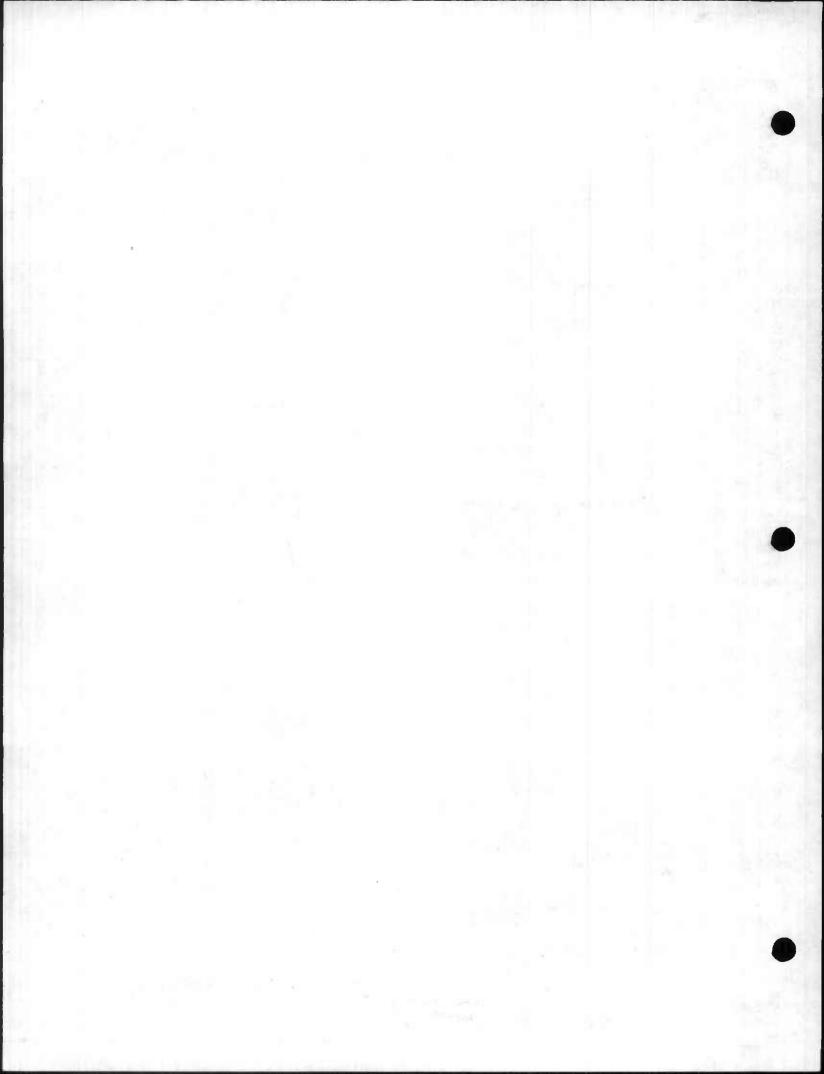
DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

30. Name and eddress of person who completed abse of death (Item 23a) (Type, Print)

32. Registrac's Signature

M.KI9



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Charlotte Ann McCullough /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Annes Hospital Baltimore 8. Date of Birth (Month, Day, Year)
Jan. 23, 1936 Pennsylvania If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□F Months 216-32-8784 63 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits mast be notified at 1 ☐ Yes 2 No Director Baltimore Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6807 Upper Mills Circle 21228 U.S.A. Nerns 23a death 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Deles: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effar a Department of Health and Mentel Hygiene. Important: If Hem 27 is marked other than "natural" natural and injury or other traumatic events. Black, White, etc. 1 Never Merried 2 Merried White 1 Yes 2 No Specify: by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Michael I. Williams Florence Orr 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6807 Upper Mills Circle, Catonsville, MD 21228 Carl Stewart McCullough Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stele 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Slete 5/19/99 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Witzke Funeral Homes, Inc. Lemmer 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) week Examiner Examiner Obstructive Pulmonary Discust Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech fibrillation, congestive 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed failure, Hypertrophic Cardiomyopa 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 8 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury al Work? 1 (Chatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medicai 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end fitle of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael S. Peattie, m.O. 900 Cator Ave Baltimore, md. 21228

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Registrar

31. Date filed (Month, Day, Year)

MAY 1 8 1999

mc Cullough

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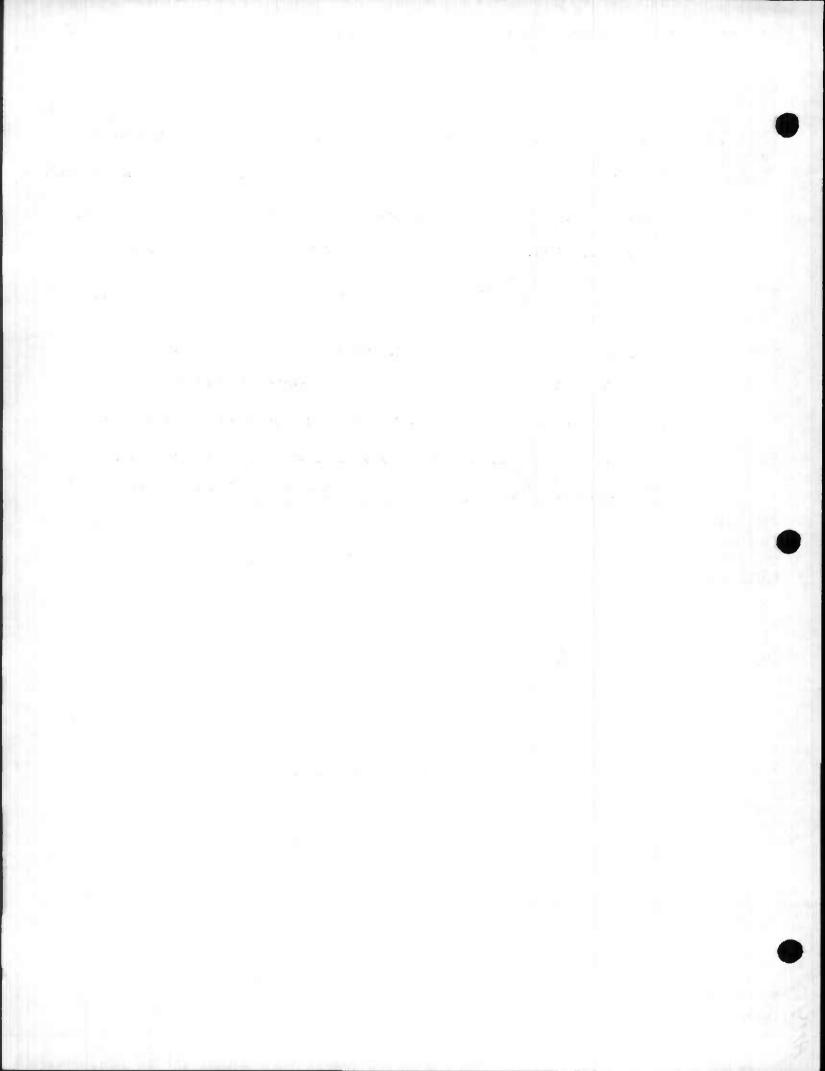
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Yeer Elizabeth Moore ma 99 12 /Medical 4e. Facility Nemo (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** BALTIMORE IRVINGTON KNOLLS CARE CENTER BALTIMORE if Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours Months 1 ☐ M 2 🛣 🗷 Yrs. 78 Director 214-24-8457 JAN 16 1921 NORTH CAROLINA Usual Residence of Decedent the Marylenc 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at XX Yes 2 □ No Director BALTIMORE CITY MARYLAND N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21217 2027 DIVISION STREET death Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Reca - American indien, Bleck, White, etc. 11. Maritei Stetus 2 should be filled within 72 hours efter and Mental Hygiene. Is marked other than "natural", or ite 1 Never Merried 2 Married 1 ☐ Yes XXNo If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ r res, Give reer or Detes: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) COSMETOLOGY BEAUTICIAN 12th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) ELIZABETH PORTER THOMAS HICKS Lo 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) s 1 and 2 s of Health an item 27 la 2027 Division Street/Baltimore, Maryland 21217 Ernest Moore/Husband 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Department of He
Important: If iten
eny injury or oth 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 5-17-99 BALTIMORE, MARYLAND 4 □ Donetion 5XXOther (Specify) Entombment LOUDON PARK CEMETERY 22. Name end Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Pert1. Enter the diseese, or complications that caused the shock, or heart feilure. List only one cause on each line or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Atherosclashic Condiovascular 10 Yust **Examiner** Due to (or es e consequence of): Examiner obe sit attending physician and for use as the buriel-transit Due to (or as e consequence of): Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated exacts) Box 68760, certificate be Physician/Medical thet initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 dnknown Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? 1□ Yes 2□No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P uneral 28e. Date of Injury (Month, Day Year) s effer death.
I Director: After the in by the funera 27. Menner of Deeth 28d. Describe how injury occurred Certification: Division 1 Neture 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 | Homicide To the Hospital within 24 hours e To the Funerel E 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

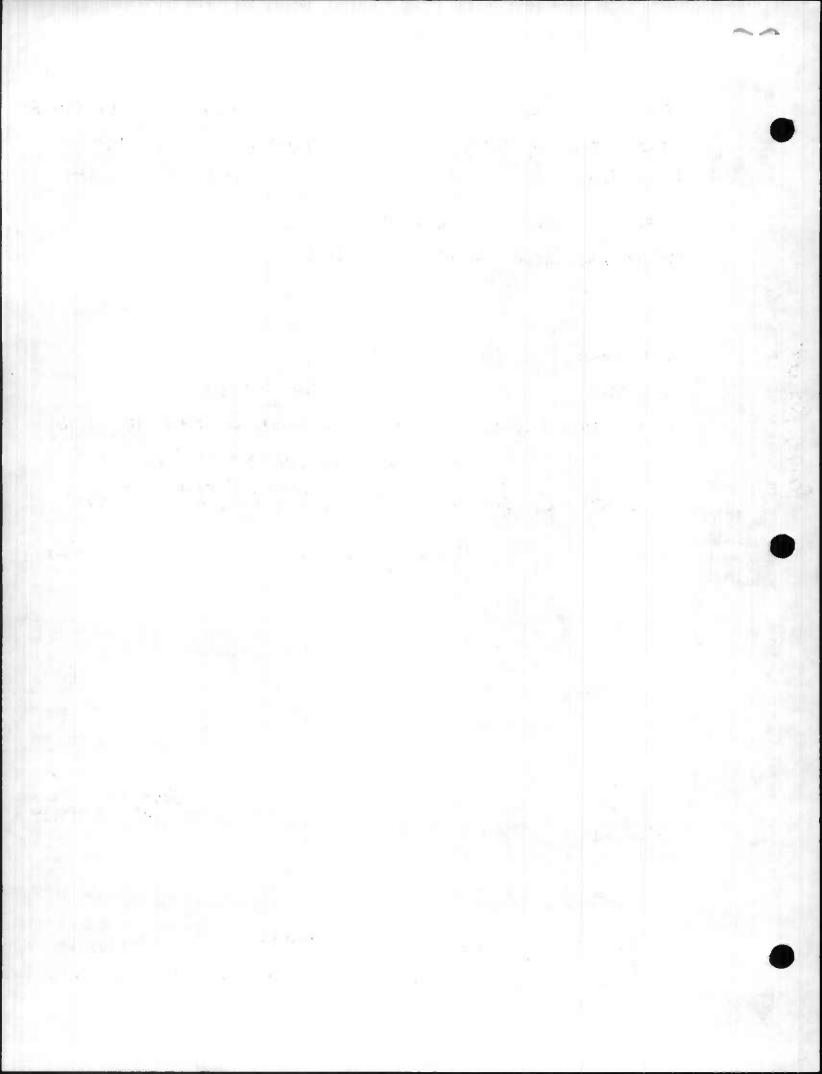
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29e. Certifier Medical (Check only one) 29b. Signeture end title of cartifier 29d. Dete signed (Month, Dey, Year) 29c. License number mien - P 93186 F mian - O Krofune 5-13-30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 821 autan Rm 206 Balt imac N street 32. Registrar's Signeture State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 4b. City, Town, or Location of Death 1999 5:40 PM KOBERT PAIGE /Medical 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner NIA IYLARIS 41 BALTIMORE TELLA If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 01-13-33 Birthpiace (State or Foreign (Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Days 12 M 2DF Months Hours Min. 420 - 38 - 1038 Usuai Rasidance of Decedent Yrs. Director 66 4LABAMA the Marylenc 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 28a-f show maps and a linear at its marked other than "natural", or frame 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be not that at once. 1. Yes 2 □ No Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 21216 POPULAR GROVE USA Funeral death 12. Was Decedant Evar in U,S Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2☑ No Specify: BLACK P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mentel Hyglene. Important: If item 27 is marked other than "r Elamentary/Secondary (0-12) Coilega (#-4or 5+) 12 11 FOREMAN GRADE NIA dige, Robert 18. Mothar's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middla, Last) Be PAIGE IDA APPLEBEE 2 UTIS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) POPULAR GROVE BALTO. MD. 21216 WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State BALTO. 4 ☐ Donation 5 ☐ Other (Specify) 5-22-99 WOODLAWN CEMETERY 21. Signatura of Funarul Sorvice Licensaa 22. Nama and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the displace, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrast, shock, or hear failure. List only one cause on each line. BALTO. MO. Approximata Interval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) /Medical mendon Examiner Dua to (or as a consequence of) Examiner physician and s the buriel-trans Sequantially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of): SE use : ò ed by the e 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, 2 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s nes 1 Yes certificate 26. Place of Death (Check only MATIS AT METCY or Attending Physician: luneral director, 25. Was cesa referred to medical examiner? Be Other: 4 Nursing Home 5 Realdence 6 Dother (Specify) > piv 1 Yes 3□ DOA Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient After this 28a. Data of injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending efter death. 1 Yes 2 No 2 Accident investigation 6 Could not ba determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 24 hours e Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and dua to the ceuse(s) and manner as stated. Medicai completely Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only / within 2 To the 29c. License number 29d. Data signad (Month, Day, Year) 29b. Signature and titia of certifier 40854 M 30. Nama an addrass of person who complated cause of death (Item 23a) (Type, Print) Bultimer 21203 Paul PI 301 MO Lisebers

32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 405 **Physician** om NNET OREATHA (KENS /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Baltmore Cit General maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days 59 Hours ntry Director LAND UNKNOWN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Magnesi Experient must be notified at Yes 2 □ No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10. Citizen of What Country? With 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No Herna 23a 200 Funerai 14. Raca - American Indien, Biack, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Maryland 21215-0020 Specify. λq H Yes. Give BLACK 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Haalth and Mental Hygiane. Important: if Item 27 is marked other than *eny injury or other treumatic event, traument pages. Elementary/Secondary (0-12) Coilege (1-4or 5+) HOMEMAKER OWN 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be CURE VMOND SEORGE ELIZABETH HARCUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SISTER 205 N. AMITY ST., APT. G. BALTO, MD. 21223 Date 20c. Location - City or Town, State LIELORES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State CEMETERY 05-18-9 4 □ Donation 5 □ Other (Specify) LANSDOWNE, MD 22. Name and Address of Fecility 21. Signalure of Funeral Se BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNGRAL HOM 2140 N. FULTON AVE. BALTO, MD. 2121 Approximate Interval Between Onset end Death Her the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest or hear failure. List only one cause on each line. **Physician** tructive Pulmonary Disease Immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Examiner nsion attanding physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest nce Box 68760. Physician/Medical Due to (or es a conseque 88 signed by the at id be detached fo Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Onknown Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy should peen : page 2 has 2 12 No 1 Yes 1 ☐ Yes 2 ☐ No certificate : After this certification of funeral director, p To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steled. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steled. 29a. Certifier edicai completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature of certifier hazala 12667

State Registrar

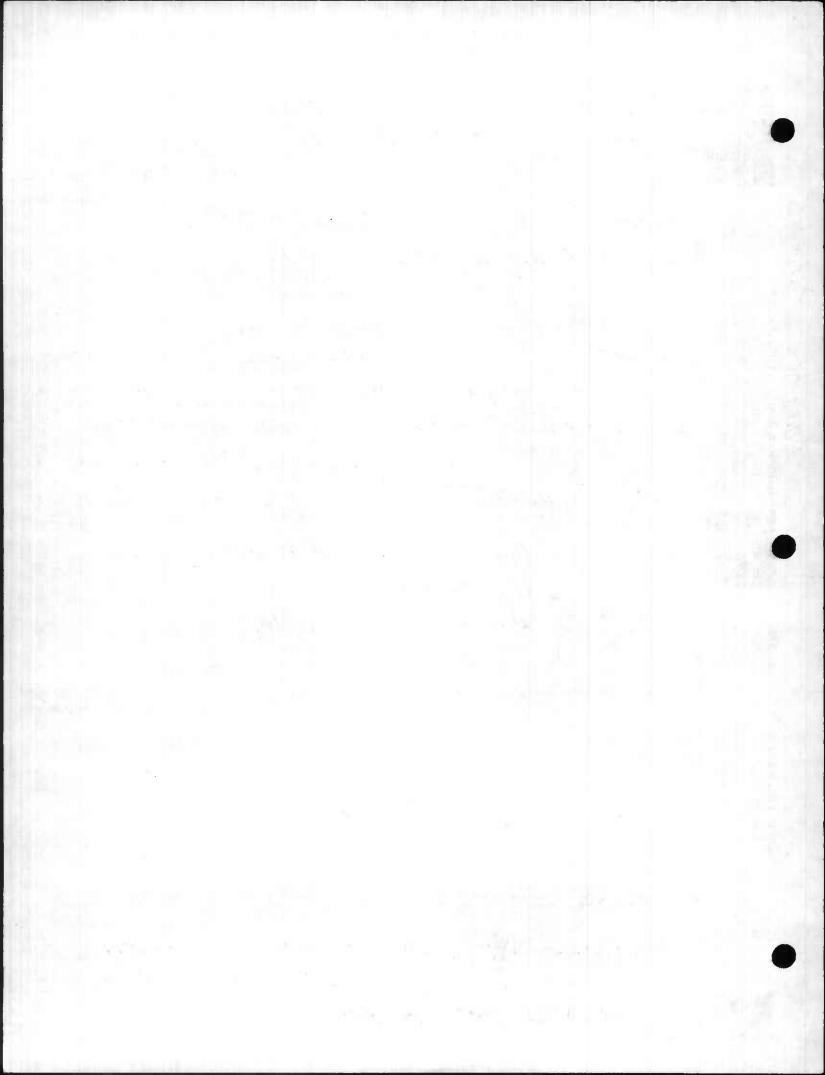
31. Date filed (Month, Day, Year) MAY 18

Thazala

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ghazala Afaa, m.n. 40 Mary 32. Registrar's Signature

maryland beneral Hospital



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED #10e & 10f PER FH G771 5/18/99 AH 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death ROLAND **Physician** 1999 MAG /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner W. Coldspring LAME BaltiMer 3820 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 8. Sex 121M 2□ F 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stata or Foraign Country) 220-64-3565 44 Yrs. Director Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at BOLHINOTE 1 Yes 2 No Directo Harylmo 10f. Zip Code 21215 10e. Street and Number 3820 W COLDSPRING LANE 10g, Citizen of What Country? 2/2/1 USA Funeral Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 11. Merital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sm 27 is marked other than "natural", or ita 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yas, Give Year or Dates: 1 ☐ Yes → No Specify: 3 ☐ Widowed 4 Divorced by Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b Kind of Business/Industry HUZES RILAND Elementary/Secondary (0-12) College (1-4or 5+) LABOTER grade 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fether's Neme (First, Middle, Last) Magdaline Sones ROLAND LEE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Parker IRUTHER 923 N. Gilmor Street permit. Pages 1 end 2 Department of Health a Important: If Item 27 is Boltmar Red Ragdaline 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State 9 Lion Cemetery Boltineux Injury 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility CHATMEM - HARRISS STEPSTOWN LUMB 21. Signature of Funeral Service Licensee any ir 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsat and Daath **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) AIDS 8 YEARS **Examiner** Due to (or as e consequence of): Examiner the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Physician/Medical Due to (or as a consequenca of): 80 USB (Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Unknown 1 ☐ Yss 2 ☐ No END STAGE RENM DISEASE by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4□ Nursing Home 5 Residence 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 8 Other (Specify) 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work?

and

Holand Parke

with the Marylend

altimore,

1 Natural 2 Accident

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

MD

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

1 Tyes 2 No

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 ☐ Sulcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. 29c. License number

Juse Inton

D 06933

29d. Date signed (Month, Dey, Year)

Registrar

Medicai

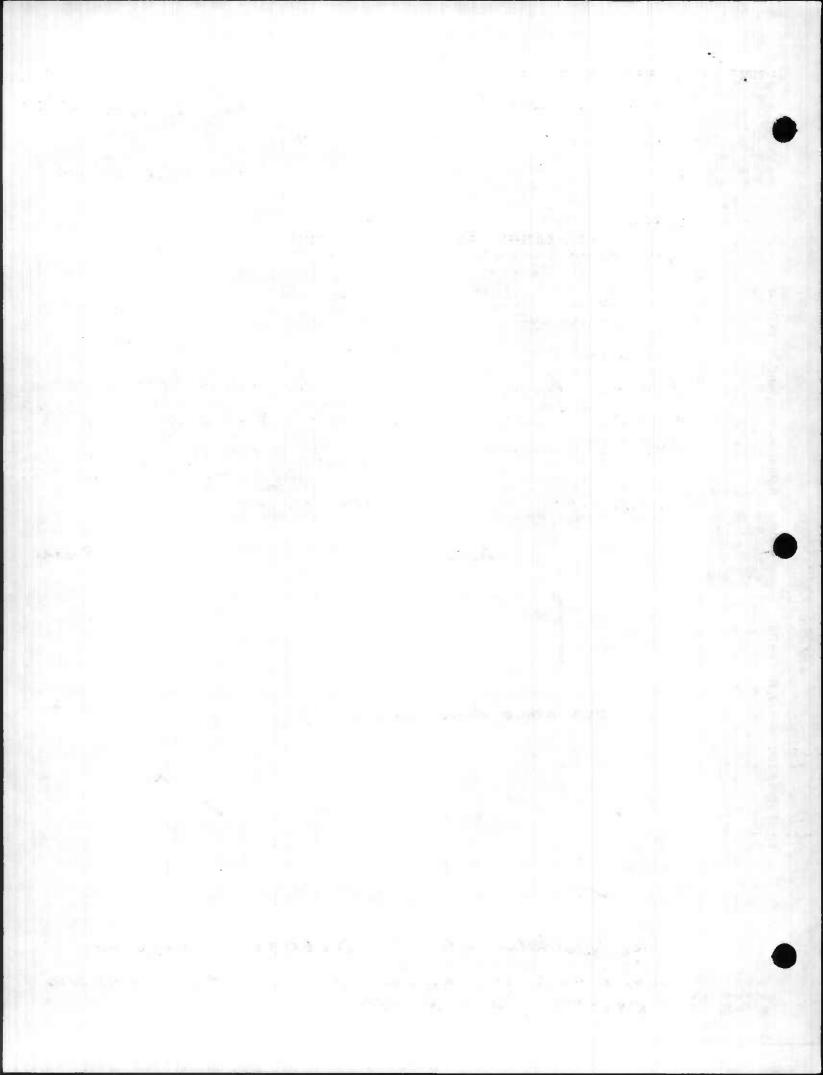
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DHMH 16 Rsv 6/95

24 hours after deat Funeral Director:

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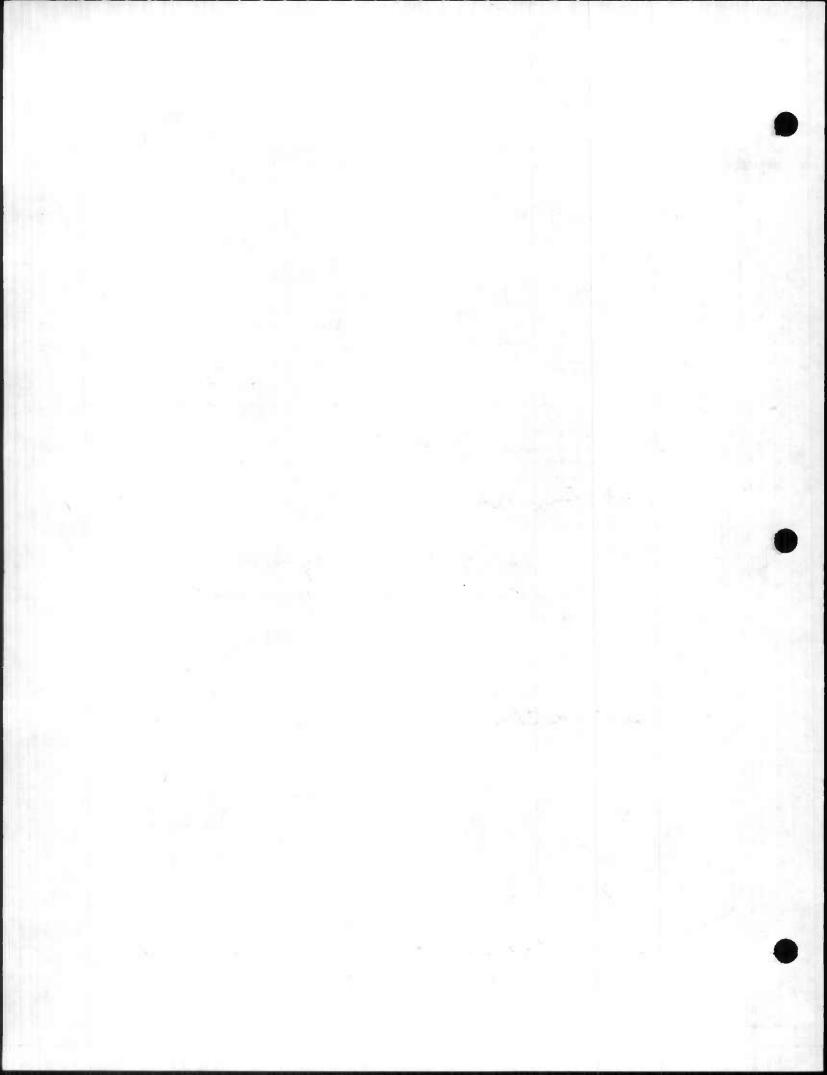
Hospital



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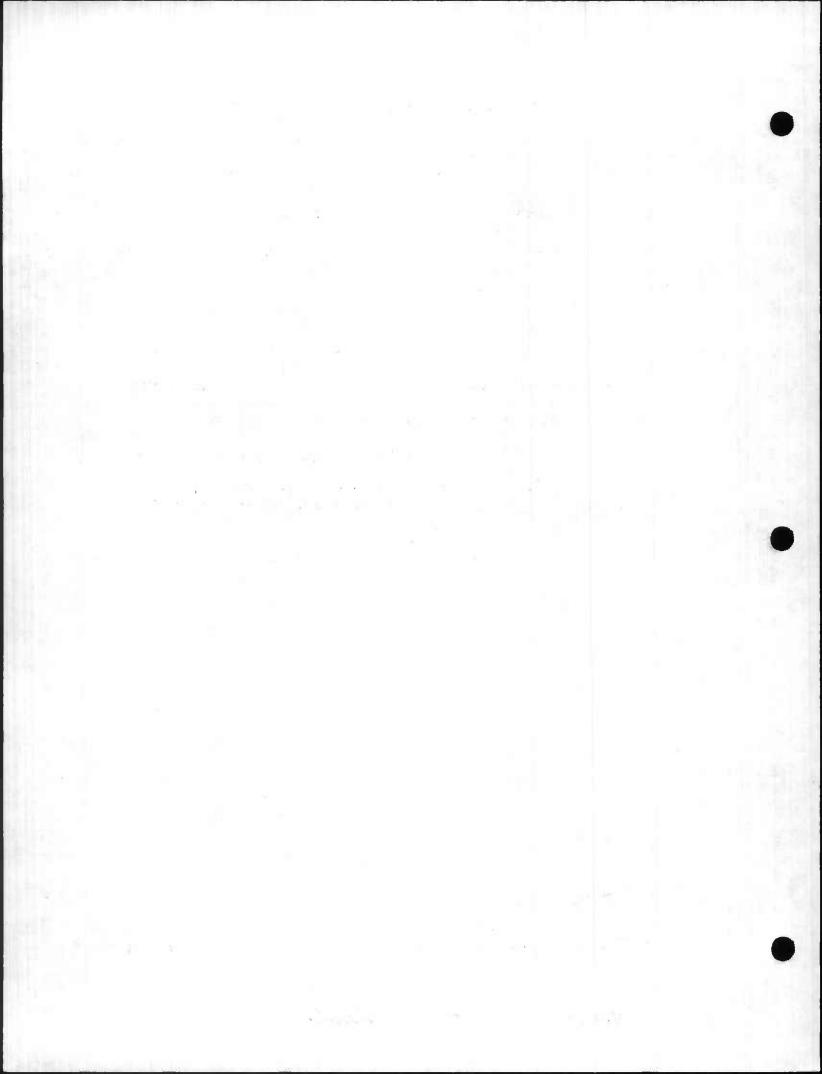
State of Maryland / Department of Health and Mental Hygiene

	Certificate of L	Death Reg. No. 99 59 0						
Physician	1. Decedent's Neme (First, Middle, Last) MaryAnn Pierce	2. Date of Death May 16, 1999 Year 7:45am						
/Medical Examiner	4a Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of Death olumbia 4c. County of Death Howard						
Funeral Director	5. Social Security Number 481-60-6638 6. Sex 1	Hours Min. 8. Date of Birth (Month, Day, Year) April 28, 1948 1						
P-04	Usuel Residence of Decedent							
art show iffed at	MD Howard Columbia	10d. Inside City Limi 1 ☐ Yes 2 🗗						
Seath with the Maryla ms 23s or 28s-f sho must be notified at teral Director	10e. Street and Number 10f. Zip Code 9252 Brush Run 21045	10g. Citizen of What Country? U.S.A.						
ar, or the Examine by Fur	11. Merital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Never Merried 2 ☑ Merried 1 □ Yes 2 ☑ No	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) Specify: Specify: 14. Race - American Indien, Bleck, White, etc. Specify: White						
72 ho netur dical	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done diffe. DO NOT use retired,	tion 16b. Kind of Business/Industry						
od within 72 ho yglane. er than "natur 4, the Medical. Completed	Elementary/Secondary (0-12) College (1-4or 5+) Administrative							
on the files ential Hyginal Hy	17. Father's Neme (First, Middle, Last) Leo WImmer	18. Mother's Name (First, Middle, Maiden Sumame) Berneice Strait						
and Me	19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street &	and Number or Rural Route Number, City or Town, Stete, Zip Code)						
Death Party		nn, Columbia, MD 21045						
nam of H	20a. Method of Disposition 1 □XBurial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery, Crematory) or other plece of Disposition (Name of cemetery).							
Departra Imports any inja	21. Signeture of Funeral Service Licensee 22. Name and Addres 5555 Twin	s of Fecility Witzke Funeral HOmes, Inc. Knolls Road, Columbia, MD 21045						
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying							
serincate be executed ding physician and se as the buriel-transit	Cause (Disease or injury that initialed events resulting in death) Last Due to (or es a consequence of):							
signed by the attending to be detached for use at by Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give	\/						
seen signed by should be detacted by Ph	Deaketes melleties	1 Yes 20 No 3 Probably 4 Unkno						
Poor Poor		24a. Was an autopsy performed? 24b. Were eutopsy finding available prior to completion of cause of death?						
page Com		1 Yes 2 No 1 Yes 2 No						
scentificate has b lirector, page 2 s	25. Was case referred to medical	26. Place of Deeth (Check only one)						
nis cer il direc	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other							
2 2 6	27. Manger of Death 1 Netural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work 1 Accident investigation	at 28d. Describe how injury occurred ? /es 2 \[\subseteq No \]						
SERE I	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attending From To the Functal Director: After completely filled in by the funer Completely filled in by the funer Medical Certification:	29e. Certifier (Check only one) 1 Certifying Physician: To the basis of my knowledge, death occurred et the time (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my operand menner steted.	e, date and place, end due to the cause(s) and manner as stated. inion, deeth occurred at the time, date end place, and due to the cause(s)						
Ithin 2	29b. Signature and title of certifier 29c. License	number 29d. Dete signed (Month, Day, Year)						
8 4 8 =	m and	820 5/17/99						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
φ	GREGORY D. MCCORMACK MD							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dav Year **Physician** 3:00pm Dennis Theodore Purcell Jr. 15 1999 May /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7610 Spruce Road Dunda1k Baltimore 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, 1) March 8 Birthplace (State or Foreign Country) **Funeral** Days Months 1₹ M 2□ F Hours 217-84-5962 24 1975 Maryland Director Usual Residence of Decedent 10a. Siele 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. **Balitmore** Dunda1k 1 Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b Ä 7610 Spruce Road 21222 USA Items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Yeer or Detes: 1⊠ Never Married 2 Merried Baltimore, Maryland 21215-0020 ò 1 Ves 2K No Specify Specify: þ White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondery (0-12) College (1-4or 5+) 3rd College Student 17. Falher's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant; if Nem 27 is marked oth lury or other traumatic even Be Dennis T. Purcell Sr. Ruth Eillen Warren 19a. tntormeni's Neme/Relellonship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dennis T. Purcell /father 7610 Spruce Road Baltimore Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other piece) Dele 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel trom Stele Sacred Heart of Jesus 5/19/99 Baltimore Md. 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Neme and Address of Fecility Connelly Funeral Home of Essex 300 MACE Ave. Baltimore Md. 21221 po not enter the mode of dying, such as cardiac or respiretory arrest. Part1. Enter the disease, or com-shock, or heart tailure. List only plications that caused the death. one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer 2 years Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last pul Due to (or es e consequence of) Box 68760. Physician/Medical the Due to (or es e consequence ot) **USB 88** signed by the attent Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? Records, P.O. 1 Yes 25(No 3 Probably 4 Unknown Be Completed by 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy parformed? page 2 s has certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vitai or Attending Physician: 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Dele of Injury (Month, Dey Year) 27 Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending investigation death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, term, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitai 29e. Certifier Medical 1 Cortifying Physician: To like best of my knowledge, death occurred el the time, date and plece, end due to the cause(s) and menner as stated. completely (Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stelled. within 2 To the 94 29b. Signeture end title ot certitier 29c. License number 29d. Date signed (Month, Day, Year) MD RE3-000 May, 13, 1999 30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print) Abenga Brewster Hopkins Hospital Johns 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar MAY 18 1999



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth Month ROESLER **Physician** ELIZABETH 15 11-45 A 05-/Medical 4e Facility Neme (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth Examiner LAUREL If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, LAUREL REGIONAL HOSPITAL PRINCE GEORGE 7. Age (In yrs. last birthday) If Under 1 Year 5 Social Sacurity Number Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2 F 80 Yrs. WEST VIRGINIA Director 236-20-0815 Usual Rasidanca of Dacedan the Marylend 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f shifts Medical Examiner must be notified 1 ☐ Yas 2 No Directo MARYLAND ANNE ARUNDEL **JESSUP** 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 20794 U.S.A. 7810 CLARK ROAD - E-21 death Funeral 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Stetus 1 Naver Married 2 Married 1 ☐ Yas 2 🗓 No Specify: Specify: WHITE þ 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12TH GRADE HOMEMAKER 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) Be Pages 1 and 2 should be found to the found of Health and Mental I not II them 27 is marked of FRANKLIN PIFER GRACE SCHAFFER 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 7810 CLARK ROAD - E-21 - JESSUP, MARYLAND 20794 CARROLL H. ROESLER (HUSBAND) 20b. Placa of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta 155 Burial 2 ☐ Cremation 3 ☐ Removal from State CRESTLAWN CEMETERY 5/19/99 MARRIOTTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22 Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 e, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, List only one cause on each line. **Physician** BRONCHIOALVEOLAR CARCINOMA /Medical Immediata Causa (Final disaese or condition resulting in death) Examiner Dua to (or as a consequence of): RUGHT LUNG NON-MUCINOUS Dua to (or as a consequence of): 5-MONTHS Examiner physician end the burial-transit Sequantielly list conditions, if eny, laading to Immadiata cause. Enter Undarfying Cause (Disaase or Injury thet Initiated evants rasulting in daath) Lest NECROTIZING PNEUMONIA LEFT Dua to (or as a consequence of): LUNG Physician/Medicai NON-MUCINOUS BRONCHOALUEOLAR Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco uea contribute to the cause of death? BRONCHITIS. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC be det þ 24b. Wara autopsy findings eveileble prior to complation of causa of deeth? CORONARY ARTERY DISEASE 24a. Was an autopsy Completed ate hes bege 2 s 1 Yas 20 No 1 □ Yas 2 □ No or Attending Physician: Be 25. Was casa refarred to medical 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 27. Mennar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Neturel 5 Panding invastigation 1 ☐ Yas 2 ☐ No 24 hours efter deeth. 2 Accident 6 Could not be daterminad 3 Suicide 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida Certifying Physicien: To the bast of my knowledge, deeth occurred et the time, data end plece, end due to the cause(s) end mannar as stated. 2 Medical Exeminar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and mannar stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifian

Baltimore,

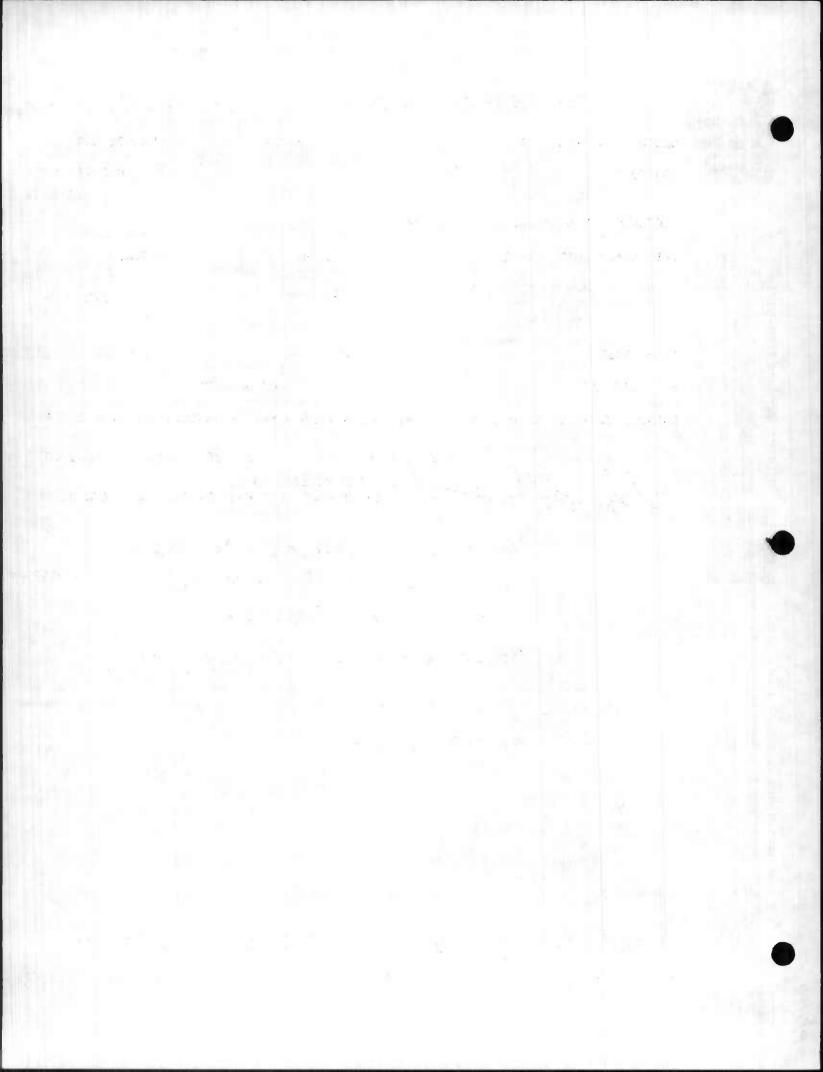
Division of Vital Records, P.O. Box 68760

State Registrar

of person who completed cause of deeth (Item 23e) (Type, Print)

NAYEEM, M.D. 3450-FORT MEADE ROAD, SUITE 100, LAUREL M.D.20724 32. Registrar's Signetyre

D21294



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				ertifica	ate of	Death		Reg. No.	9	5913	
Division	1. Decedent's Nama (First, Middla, I	_ast)					2. Data of D		Veer	3. Time of Death	
Physician /Medical	Andrew	P. REDYK					MAY	13	1999	0530	
Examiner	4a Facility Nama (If not Institution, g	iva street and number)			4	tb. City, Town, or	Location of Dea	th 4c. Count	ty of Death		
40	CHURCH HOSPITAL					ALTIMOR			NA		
Funeral Director		Sax 7. Aga (I	n yrs. last birthe	Month	S Days	If Undar 24 Hr. Hours Mir		Deta of Birth (Month, Day, Year) Jan 31,1915 Birthplace (Stata or Foraign Country) MD			
Due John Market	10a. Stata 10b. County	10	Oc. City, Town o	or Location				10d. Inside City Limits			
GDY GDY Feeto	MD N/	A 1	BALTIMO	RE						1 Yas 2 X40	
と ES A MARIA	10e. Street and Number 2621 FAIT AVENUE	2		21	Zip Code			10g. Citizen of	What Countr US	•	
by Fu	3 ☐Widowed 4 ☐ Divorced	12. Was Decedent Eva Armed Forcas? 1 Yas No If Yas, Give Yaar or Datas:	ır in U,S.		edent of Hoecify Cube	lispanic Origin? (an, Mexican, Pua Specify:	Specify Yas or Norto Rican, atc.)	Specify			
od within 72 hours giene 77 N DE E W veril territoria,	15. Decedent's (Spacify only highast of	Education	16a. D	ecedent's Us	sual Occup	ation	ndkina	16b. Kind of E	Business/Indu	ustry	
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A POPULATION OF THE POPULATION	9			BAKER				BAKERY	12		
SE SE	17. Father's Name (First, Middla, La	st)					ıma (First, Middle	a, Maiden Suma	ma)		
목행물을 이	THOMAS REDYK					UNK	NOWN				
and 2 sho eith and 27 is m or treum	19a. informant's Name/Ralationship DANIEL REDYK	(Type, Print)		19b. Mailing Addrass (Street and Number or Rural II 3004 EDWARDS AVENUE,							
emit. Pages 1 a department of Her mportant: If Nem iny Injury or othe	20a. Mathod of Disposition ★ Buriai 2 □ Cramation 3	A CO. CO. CO. CO. CO. CO. CO. CO. CO. CO.	20b. Place of D cematary,	risposition (A cramatory o		>e)	Data	20c. Location	- City or Tow	m, Stata	
ortant: Page properties injury	4 Donation 5 Othar (Spec		ST. STAN	ISLAUS	CEMETE	RY	May171999	BAI	TIMOR	E, MD	
Addical Examiner	23a. Part1. Enter the disaasa, or shock, or haart failura. List on Immediata Causa (Final disaasa or condition rasulting in death) Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last	a. ACUTE Du CONGE Du c. HYPERTO	RENA a to (or as a con STIVE a to (or as a con	AL 7 Insequence of ATHG1	FAIL n: RT n: ROSCL	URE FAILU	e <i>e</i>			Approximate Interval Between Onsat and Death Weeks Years F Years	
ath ce for use	Part II. Other significant conditions	dcontributing to death but n	ot rasulting in t	ha underlying	o causa giv	en in Part I.	23b. Did	I tobacco usa c	ontributa to	the cause of death?	
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) > D 0 =	PERIPHERA	L VASCUL	AR DI	SEAS	6			s an autopsy ormed?	avai	ra autopsy findings ilable prior to aplation of cause leath?	
The late he page							10	Yas 2 10 No	10	Yas 20Mo	
certificate hes rector, page 2	25. Was casa refarred to medical axaminar?					26. Place of De	eath (Check only	ona)			
Ing Phy After this funeral d	axammar 7 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident invastigate	Hospital: 1 Inpatient 28a. Data of Injury (Month, Day Yo	2 ER/Outp 28b. Tin Inju	na of	28c. Injur Wor	4 Nursing	Homa 5 Ras 28d. Describe	how injury occu)	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not determine	28a, Place of Injury building, atc. (5	- At home, farm Specify)	, street, fact	ory, office			(Street and Num own, Stata)	nber or Rural	Route Number,	
24 hours 24 hours Funer etely fill dical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Phyaician: To the best of manner: On the bests of example and manner stated	amination and/o	leath occurre or invastigation	ed at the tir	ne, date and place pinion, death occ	e, and due to the curred at the tima	cause(s) and n , date and place	nanner as sta , and due to	ited. the causa(s)	
Me of the omple	29b. Signetura and titla of certifiar	/ 0		2	9c. Licens	e number		29d. Date sign	ed (Month, D	Day, Year)	
F 3 F 8	> Inavarion	and Spe	ecialia	7		0356		MAY ,	13 /	1999	
	30. Nama and address of person wh	ARRO MI).		(pe, Print) BROK	DWAY	1, BAL	TIMORE	MARY	LAND	21231	
State Registrar	31. Data filed (Month, Day, Year) 19	99 32. Registrar's		9							

AH 13

The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath 3. Time of Deeth 8:30 Am Betty Mae Romm May 6 4a. Fecility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Daath Baltimore St. Elizabeth Nursing HOme Months Days Hours Min. Sept 21, 1910 Sept 21, 1910 Sept 1910 North Carolina 5. Social Security Number 219–07–9248 7. Aga (In yrs. lest birthday) 1 ☐ M 2 🖾 F 88 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6030 21228 Chesworth Road U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☑ Yes 2 ☐ NoWWII If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Social Security Accountant 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middla, Maiden Sumeme) Charles Craven Ava M. Grayson 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code) Michael J. Romm (Son) 6030 Chesworth Road, Catonsville, MD 21228

Physician /Medical

Physician

/Medical

Examiner

10a. Stata

20a. Method of Disposition

21. Signature of Funeral Service Licensaa

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

· Cicetra Kaya Mp

31. Dete filed (Month, Day, Yeer)

MAY 181999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

MD

Director

Funeral

by

Completed

Funeral

Director

28a-f show

238

Itam 27 is marked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Examiner must be notined at

"natural', or

Depertment of Health and Mental Hygiene, important: If Item 27 Is marked other than " any Injury or other traumatic event. In a second control of the seco

Examiner

Immediate Cause (Final disease or condition rasulting in death)

ettending physician end for use es the buriel-trensit Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, it

Box 68760

Examin	Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying	b. — Due to (or as e consequance o	f):		
Medical	Cause (Disease or Injury that initiated events resulting in death) Last	C. Due to (or as a consequence of	·):		
/ Physician/M	Part II. Other eignificant conditions of OSTOPONISM	contributing to death but not re	sulting in the underlying	g cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death
Completed by	Hypertensi	ion			24e. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
Bec	25. Was case raferred to medical			26. Place of De	eth (Check only one)	
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ation:	27. Manner of Deeth 1 5 Natural 5 Pending 2 Accident Investigatio	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how Injury occur	rred
Certification:	3 ☐ Sulcida 6 ☐ Could not be determined		nome, farm, street, factorify)	28f. Location (Straat end Numb City or Town, State)	ber or Rural Routa Number,	
Medical	29a. Certifier 1 Certifying Pt (Check only one)	nysicien: To the best of my kn miner: On the basis of examin and menner stated.	owledge, death occurre ation and/or Investigetion	d at the time, date and plecton, in my opinion, deeth occi	e, and due to the ceuse(s) end murred at the time, dete end place,	enner es stated. and due to the cause(s)
Σ	29b. Signature and title of certifier		2	9c. License number	29d. Date signe	ed (Month, Dey, Year)

Raya UD

Da7541

May 17, 1999

Son who completed cause of deeth (Item 23e) (Type, Print)

RAJA, 4367 HOWING FERRY RD, BALTIMORE, MD 21227

20b. Place of Disposition (Name of cemetery, cremetory or other place)

23e. Part1. Entar tha disease, or of milications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List of the one cause on each line.

Due to (or as a consequence of):

Woodlawn Cemetery

. Aut Cerebrovasenlen Aceident

20c. Location - City or Town, State

week

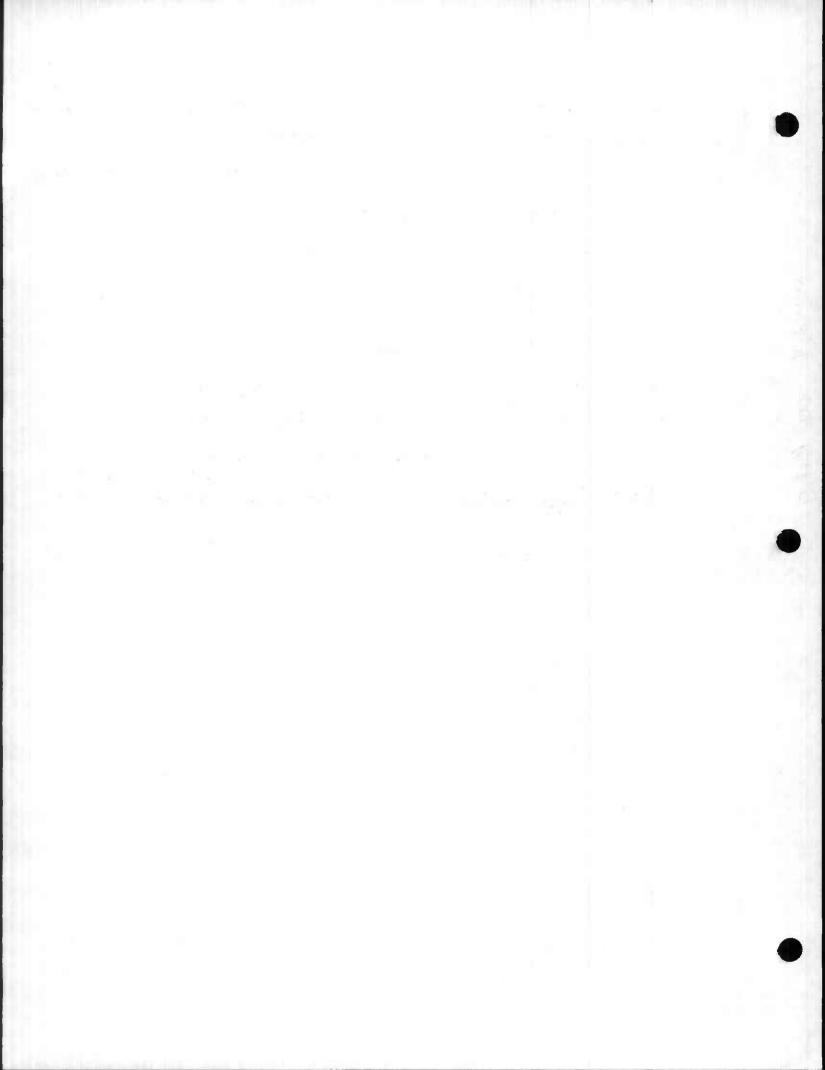
5/18/99 Woodlawn, Maryland

22. Name and Address of Fecility Witzke Funeral HOmes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

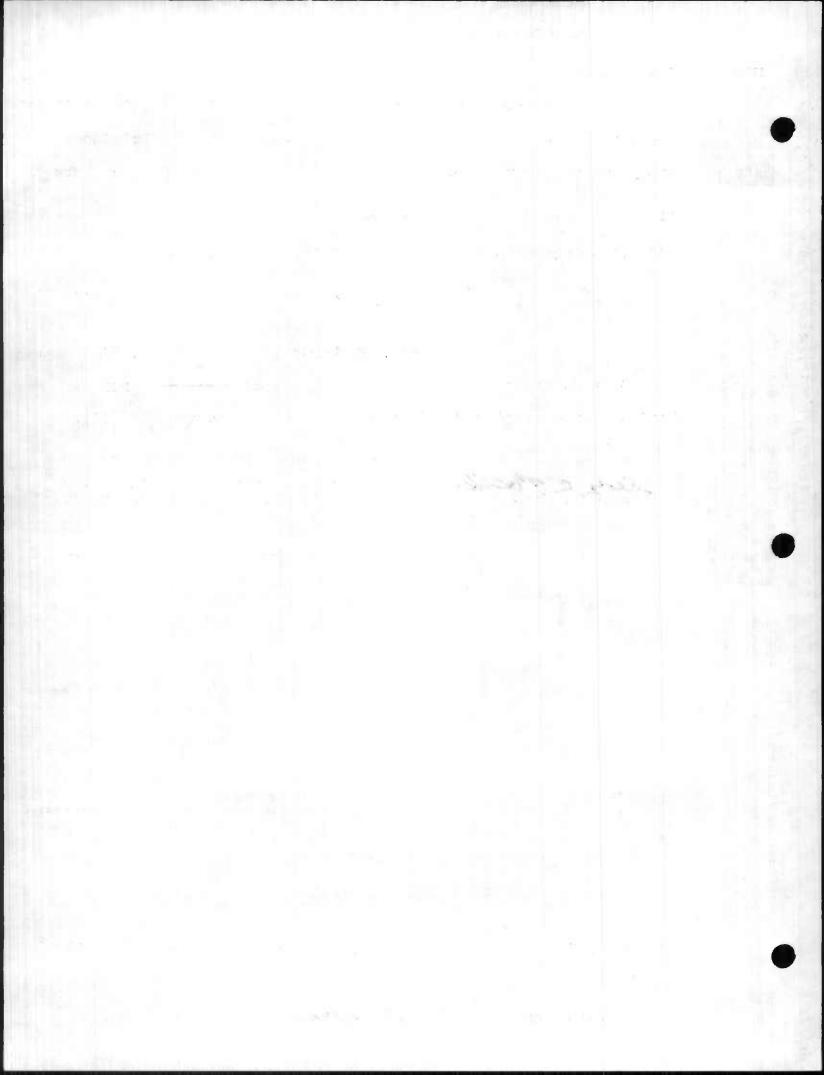
DHMH 16 Rev 6/95

State

Registrar



310	ITEM:	: #18 P	ER F.H. G772 6-1-99 WR.	State of Man		epartme Certifica				giene 9	9 1	59	15
mill	D	hysician	1. Decedent's Name (First, Middla, La		0				2. Dete of De Month		Year		of Death
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	E	xaminer	4a Facility Name (If not institution, give					4b. City, Town, or I	Location of Death		ty of Death		
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194	7, 1	rector		ADM ADE		Month		Hours Min.	8. Date of Bird (Month, Da APR 7,	1919	New	Yor	k k
10	Maryland	iled at	10a. Stete 10b. County	_	Oc. City, Town	or Location	ne				1		City Limits
May	with the	3s or 28a-1 s at be notified	10e. Street and Number 808 Willow Cre	eek Lane		10f.	Zip Code	941		10g. Citizen of USA	What Cour	ntry?	
7.	doati	iner must iner must Funeral	11. Marital Status	12. Was Decedent Eve	er in U,S.	13. Was De	cedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Ra	ca - Americ		
1	215-0020 min 72 hours after	by Era	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 You it Yes, Give Year or Dates:	4.47			Specify:	o Alcan, etc.)		ack, White,		
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1	e, Ma	m Z7 is her trau	Sandra S. Con	no11y/daught	ter 43	Spor	t Hi	11 Pkwy	. Eas	ton, C	T 06	612	
EEM,	Pages Pages Insert of H	ury or of	20a. Method of Disposition 1 Burlal 2 Kremation 3 5 4 Donation 5 Other (Speci	JHemoval from State	20b. Place of cematery Metro			, Inc. 5/	18/99	Balti			
8	Ball permit. Depart	any inj ans inj	21. Signature Funeral Service Lica	1. (E.1HT		Cre 299	and Address	on Soci derick	ety of	Mary1	and,	Inc	228
•	/Me	sician edical miner	23a. Part1. Enter the disease, or com shock, or heart tellure. List only Immediate Cause (Final disease or condition resulting in death)	a. P6	e death. Do not be death. Do not be death. Do not be death. Do not be death.	catio	c c	ng, such as cardiad		rrest,		Onset a	mete Between nd Death
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(P.O.	detached	Part II. Other significent conditions of	contributing to death but n	tot resulting in	the underlyin	g cause gr	ven in Part I.		Yes 2 X No			Unknown
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	Re le	i certificate has t lirector, page 2 s o Be Compli							10	Yes 2000	1[□ Yes	2□ No
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	ION O	e funera	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28e. Date of Injury (Month, Day Y	(ear) 28b. Ti	me of jury M	28c. Inju Wo 1	nyat irk?]Yes 2□No	28d. Describe	how Injury occi	urred		0
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	To the	Comp	29b. Signature and title of certifier	10			29c. Licens			29d. Date sign			
			171 Brothe	y/ Cully .	on		025	rdos		MAY	17,0	999	
			30. Name and address of person who	completed cause of deat	th (Item 23a) (1	Type, Print)	han	les St	Bulto	md	512	عرن	
0		State	31. Dete filed (Month, Day, Year)	32. Regfareds	Signeture	4	Same	J. 1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** SOUTHARN 3:50PM 4a. Fecility Neme If not institution, give street end number; 5 /Medical 4b. City. Town, or Location of Death **Examiner** TOWSON

If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Edenwald Baltimore If Under 1 Year Months Days 9. Birthplece (State or Foreign Country) 6. Sex 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 1□ M 20XF 146-10-5510 Yrs Director MAR 24, 1918 New Jersey Usuel Residence of Decedent pernit. Pages 1 and 2 should be liled within 72 hours effer death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examinar mass to activity. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Directo Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road 21286 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Bieck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1□ Yes X□ No Specify: by 3 Widowed 4 Divorced White Completed 16e. Decedent's Uauel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Sales Lady Department Store 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Raymond Waterman Mary O'Brien 19e. tnformant's Neme/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 109 Greenbrier Road Rae A. Disney/daughter Towson, MD 21286 20b. Plece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 5/18/99 Baltimore, MD 21. Signeture of Funeral Service ticensee Cremation Society of Maryland, E. MacNabb George Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting In deeth) **Examiner** Examiner physician and the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) signed by the atte Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by should 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 1 ☐ Yes 2 ☐ No Juneral director, 25. Wes case referred to medical examiner? 28. Plece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) To 1 Yea 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 1 Netural 5 Pending Hospital or Attending
 24 hours after death.
 Funeral Director: Aft To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the Iv 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) Medical

29c. License number

29d. Dete signed (Month, Dey, Year)

end menner stated.

32. Registrer's Signeture

geath (Itelo 23e) (Type, Print)

n who completed cause of

State Registrar 29b. Signature and title of certify

and address of pe

31. Dete filed (Month, Dey, Year)

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MARY HE SOUTHERS

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year May 15, 1999 10:10 PM Velma Beauchamp /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Min. S. Date of Birth (Month, Day, Year) 1902 Baltimore Genesis Eldercare- Loch Raven If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) IOWa Months Days 1 M 28 F 520-24-7837 97 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Directo San Diego Chula Vista 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 171 Fourth Ave. 91910-2519 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ 3 ₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Nora Levi Francis Beauchamp Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Wengate Rd. Owings Mills, MD. 21117 Harriette S. Burks (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ▲□ Donation 5 □ Other (Specify) Hilltop Service Corp. 15/17/99 Towson, MD. Carroll 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License Denna \$ 1050 York Rd. Towson, MD. 21204 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 2 No 1 Yes 1 Yes 2 No Be 25. Was case reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Natural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director;

Box 68760.

Funeral

Director

25a-f show

'natural', or flarms 23a or

Hygiene.

permit. Pages 1 and 2 should be fit Department of Health and Mentail Hy Important: If Item 27 is marked offer any Injury or other tra

Physician

/Medical Examiner

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page 2 s

certificate

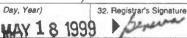
altimore, Maryland 21215-0020

Registrar **DHMH 16 Rev 6/95**

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a. Certifier



Zraz Mirenmo

30. Name and address of person who completed cause of death (frem 23s) (TYPA Print) Zia Z MITZU MN, 300 F (W3) T PARTY N Parkway, souls

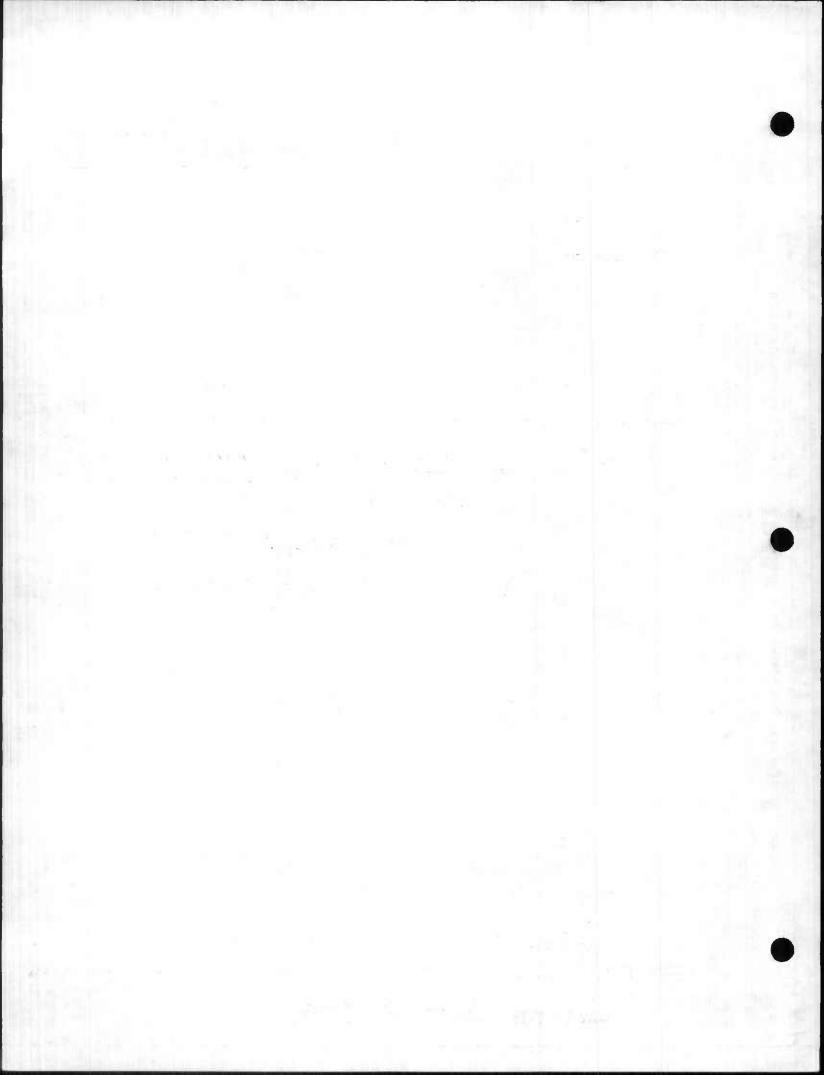
to Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

2☐ Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

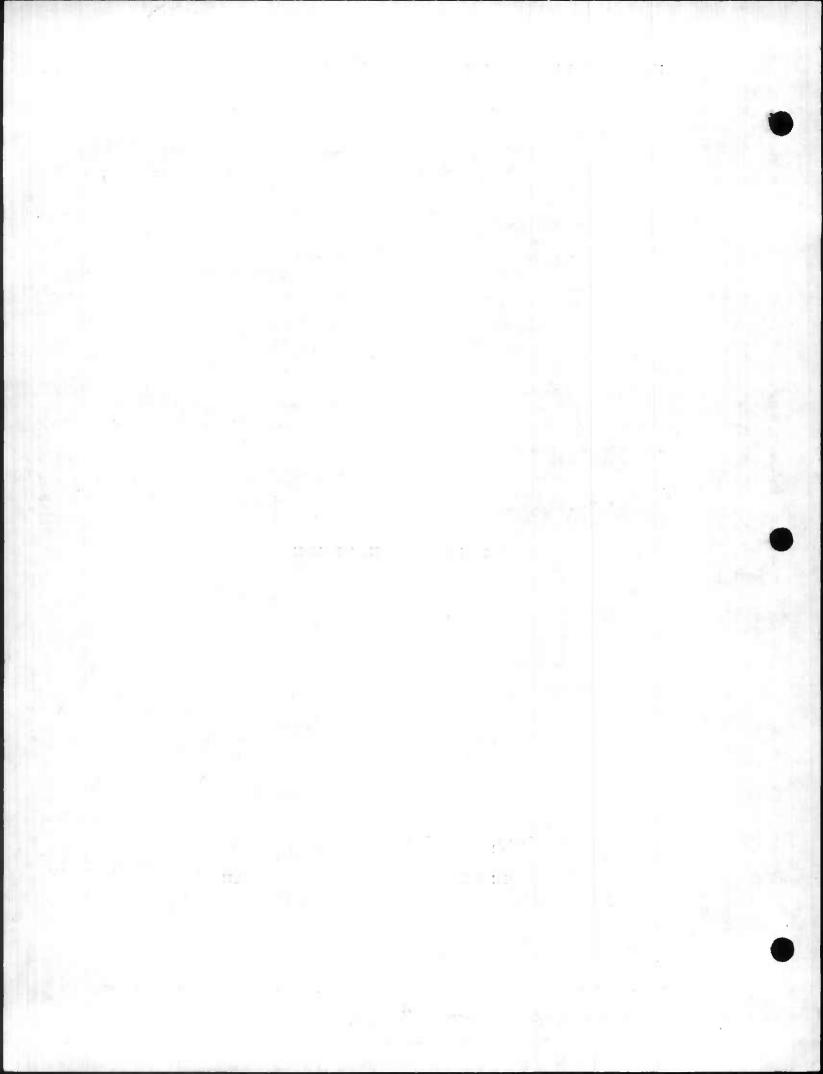
29c. License number
D41901

29d. Dete signed (Month, Day, Year)

Ballimore, MD 21214



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lical	/ / ~	GLENN ROBIN SIMMS					Month MAY]	Day 2, 1999	Year 164		
iner	4a F	4a Facility Name (If not institution, give street and number) 4b. City, Town						4b. City, Town,	or Location of Dea		of Death
		1930 DEN						BALTIM			NA
	213	ciai Security Nu	769	5. Sex 1 □ M 2 📆 F			H Under 1 Year Months Days		Min. 8. Date of B (Month, D	irth lay, Year) 21 1958	9. Birthplace (State Country)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Deeth 2. Dete of Deeth Wood row 1130 Pm may 1799 16 4e Fecility Neme (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth O. Kland BAltimore 5820 Arbutus If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex . 1 M 2 □ F Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 80 Yrs. 212016600 February 18, 1919 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Arbutus RAltimor MD 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? 21227 United States 5820 12. Wes Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11. Marital Status Bleck, White, etc. 1 Never Married 2 Merried 1□Yes 2No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Plummer 9 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumame) SydniA Shif readen 01 Indrew 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) wife 5820 04Kland Josephine M. Sh. Flet d rbutus, mid, 20a. Method of Disposition 20b. Plece of Disposition (Nama of cametery, crematory or other placa) Dete 20c. Location - City or Town, Stela 1 Buriel 2 □ Cremation 3 ⊡ Removel from Stete Brooklyn Park 201 Cemeter of Funeral Sex 1328 ice Licanspe 22. Name end Address of Fecility Ambrose 2122 4ome 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failura. List only ona cause on aech lina. Lung direase Immediate Ceuse (Finel diseasa or condition rasulting in daath) Dua to (or es e consequence of) Sequentially list conditions, if eny, laading to immediate causa. Enter Underlying Causa (Disease or Injury thal initieted events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Dld tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy periomed? 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only ona) Other: 4 Nursing Homa Seridence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Mannar of Death Neturel 2 Accidant 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of Injury 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 3 Suicide 28e. Pleca of Injury - At home, ferm, straal, fectory, offica bullding, etc. (Specify)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by t or Attending Physician: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After I

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Completed

7 is marked other than "natural", or items 23s or 28s-f shot treumstic event, the Medical Examinar must be notified at

with the Maryland

filed within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "

9

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Physician

/Medical

Examiner

attending physician and for use as the burial-transit

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Completed by Physician/Medical Examiner

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28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To tha best of my knowladga, daeth occurred et the tima, date and place, and dua to tha causa(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s)

29a. Cartifiar (Check only one) 29b. Signeture and title of certifier

29c. License number 031627

29d. Date signed (Month, Day, Year)

ss of person who completed cause of deeth (Item 23e) (Type, Print)

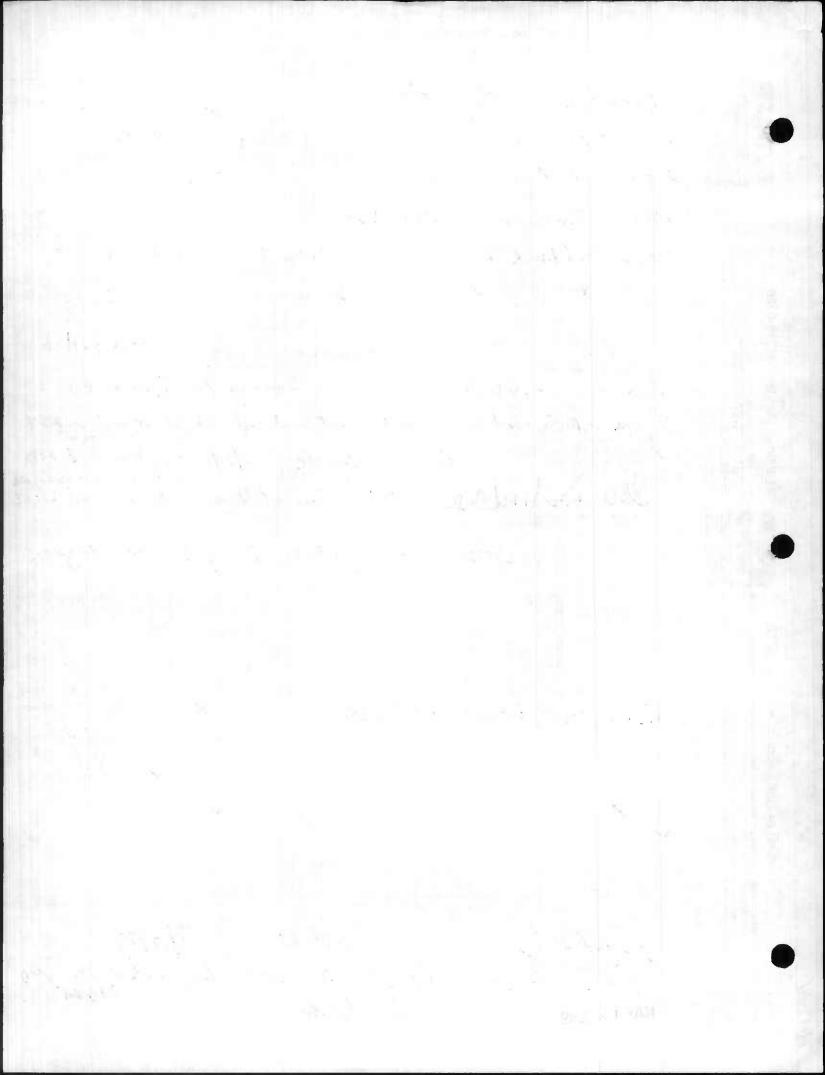
Maiden Choia LA. Cotonville

Girals 24

State Registrar

31. Dete file (Month, Day, Year) MAY 1 8 1999 32. Registrar's Signatura

end menner stated.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death FRANCES 10:00 AM STOWERS 1999 14 MAY 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HARBOR HOSPITAL CENTUR BALTIMORE If Under 24 Hrs. ff Under 1 Yeer 8. Dete of Birth (Month, Day, Year) JULY 23,1923 9. Birthplaca (State or F Country) HARTWELL, GA. 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplaca (State or Foreign Deys 1 □ M 2 🖫 F 75 Yrs 259-32-1324 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2723 BOOKERT DR. 21225 USA 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 1 No Specify: Specify: AFRO. AMERICAN 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY SCHOOL JANITOR 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANDREW PATTERSON MATTIE L. PATTERSON 19a, Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DAUGHTER LORRAINE STUKES 709 DEACON HILL CT. BALTIMORE, MARYLAND 21225 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriel 2 Cremetion 3 Removel from Stete 5/21/99 BROOKLYN, MD. 4 ☐ Donetion 5 ☐ Other (Specify) CEDAR HILL CEMETERY 21. Signature of Funeral Service Licenses ESTEP BROTHERS FUNERAL SERVICE, P.A. ESTEP LLØYD M. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death Immediate Cause (Finel PNEUMONIA 2 WEEKS disease or condition resulting in deeth) Due to (or as a consequence of): 4 YEARS TERMINAL LUNG CANCER Due to (or as a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown HEART PAILURE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to HYPERTENSION completion of cause of death?

Physician /Medical Examiner

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24 hours after Funeral Dire Hospital

or Attending after death. Director: After

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Certification: To

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Box 68760.

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Division of Vital Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at

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permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygies important: if Itam 27 is marked other the eny injury or other traumatic event, the page.

death

72 hours after

Baitlmore, Maryland 21215-0020

Director

Funeral

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Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

CONGESTIVE

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25. Wes case referred to medical

1 Yes 2 No 27. Manner of Death

1 X Natural 5 Pending 2 Accident investigation 3 Suicide

6 Could not be determined 4 Homicide

Hospitel: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Tima of

28c. Injury at Work? 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No

28d. Describe how injury occurred

2/2/No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

100 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

29b. Signeture and title of partifier LUM SHWE MRA GYAU 29c. License number 12797 INTERN

29d. Dete signed (Month, Day, Year) MAY

30. Name end address of perwho completed cause of death (ttem 23a) (Type, Print) HARBOR HOSPITAL ENTER

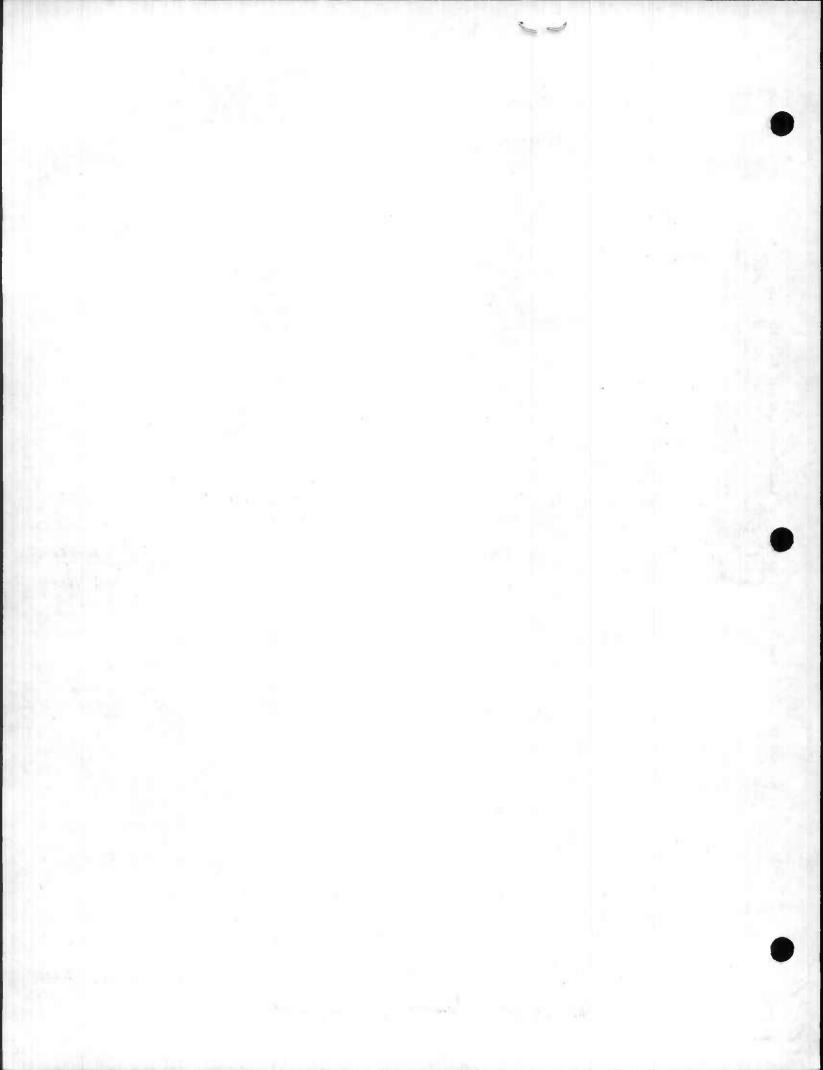
32. Registrer's Signature MAY 18 1999

3001 SOUTH MANOUEL STALLT, BALTIMORE, MARYEND souks

1 Yes 2 No

State Registrar

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 1:30 AM **Physician** Robert Smith W. May 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Name (If not institution, give street and number) BonSecour Hospital Baltimore NA If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Deys 1□M 2□ F Months Hours Min. Yrs. 212-42-6139 54 08 - 14 - 44MD Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Towson Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 528 Goucher Blvd. 21286 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Housing Authority 2yrs. Housing Inspector 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 10 Robert W. Smith, Sr. Ruth Evelyn Cornish 19e. Intorment's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Goucher Blvd. Towson, Maryland 21286 K. Marcia Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State 05-19-99 Baltimore Cemetery Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Fecility Baltimore, Maryland 21202 21. Signatura of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue MA 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence ot) Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contributa to the cause of death? onot resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown ð 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 2 No 1 ☐ Yes 1 □ Yas 2 □ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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permit. Pages 1 end 2 should be filk Department of Health end Mentel Hy Important: If item 27 is marked othe any injury or other treumatic event page.

Physician

/Medical Examiner

> State Registrar

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29a, Certifier

31. Date tiled (Month, Day, Year) 8

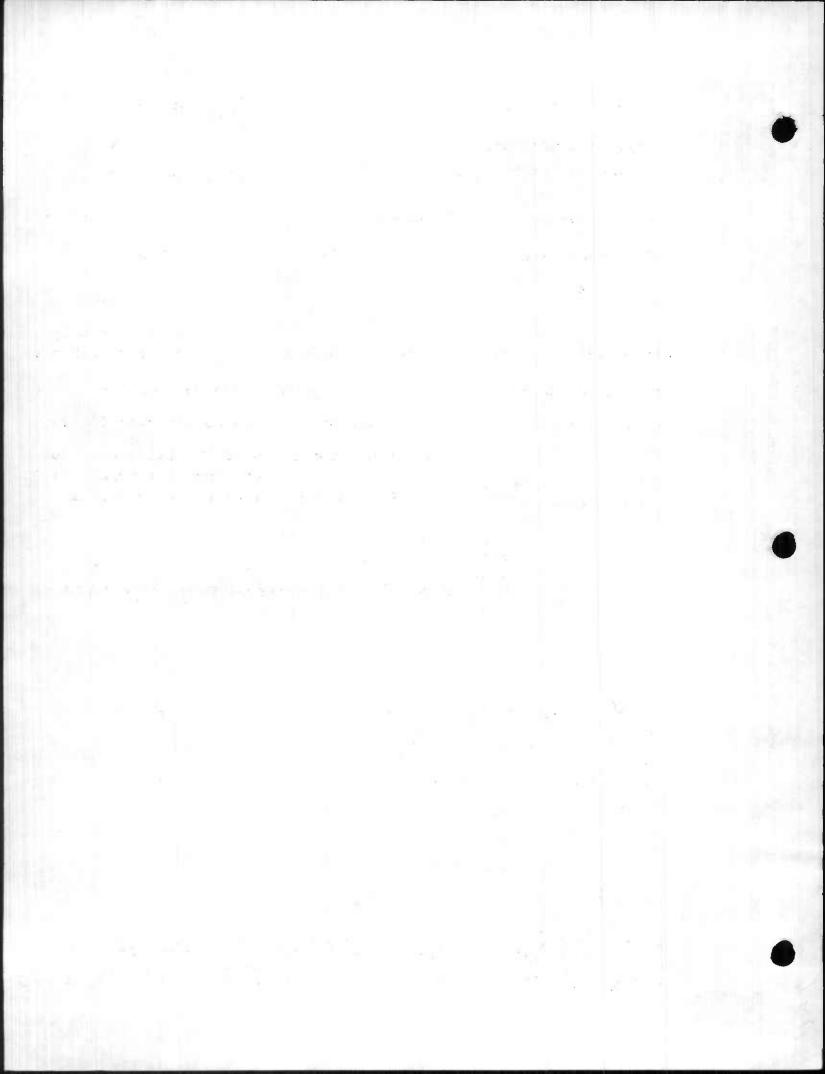
30. Neme and eddress

29b. Signature and this of certifier

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1999



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Sanders certrudene May /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Hospital Baltimore City Baltimore of H Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) 46 Yrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 M 25 F Director WASHINGTON, DO 218-60-7823 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No Director N/A md 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21239 Funeral 5811 GLENKIRK 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 Yes 20 No 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other treumetic DOMESTIC HOUSEWIFE 12 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be MARY BELL JOHNSTON GREEN HAZEL MCMANUS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) COLLIE SANDERS (HUSBAND) 5811 GLENKIRK CT, BAI, TO. MD 21239 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State A □Other (Specify) 5-21-99 BALTO. MD BALTO. NATIONAL eral Service Licens 22. Name end Address of Facility EROY O DYETT & SON FUNERAL HOME 4600 LIBERTY MD 21207 **HGHTS** AVE, BALTO. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one ceuse on each line Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner Embolus n monory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Supatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Netural
2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, or Attending within 24 hours after death.

To the Funeral Director: Af Hospital To the Pwithin 2

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filed within 72 hours after Hygiene. Ither than "natural", or its

Baltimore, Maryland 21215-0020

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Registrar DHMH 16 Rev 6/95

Brett 31. Date filed (Month, Dey, Year) State MAY 1 8 1999

(Check only one)

29b. Signeture end title of certifier

30. Name and address of person

32. Registrer's Signeture

who completed cause of deeth (Item 23a) (Type, Print)

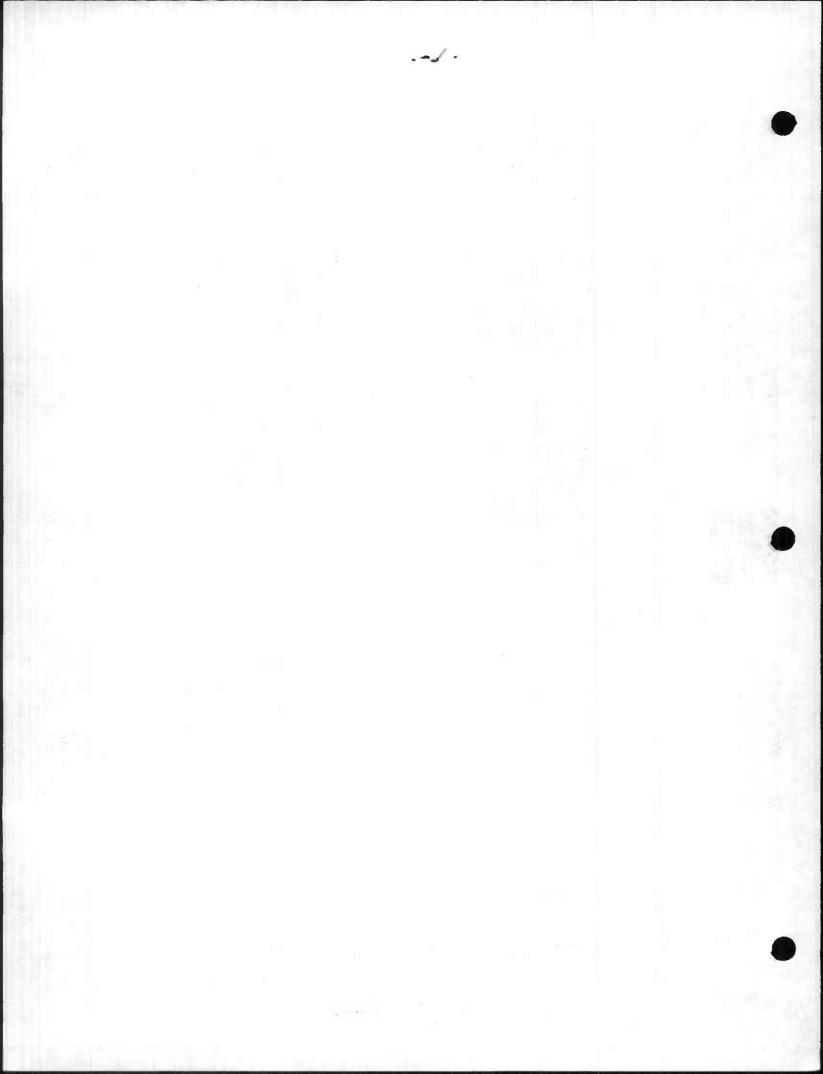
oaks

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

29d. Date signed (Month, Day, Year)

Sina! Hospital of Baltimore



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED: #8 PER FH G771 5/18/99 AH 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month pm 5 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Union Memorial Hospital If Under 24 Hrs. 8. Date of Birth Hours | Min. | 8. Date of Birth | 9. Birthplece (State or Foreign Country) | 1913 | 19. Birthplece (State or Foreign Country) | 1913 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1915 | 1 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex 1□M 2XTE Months Days Yrs. 216-82-0602 April 15, 1000 86 Maryland Usual Residence of Deceden 10a. State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1 Smeton Place, Unit 1005 21204 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 N/A Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) George Edward Parker Sara Ann Gerlach 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 35 Club View Lane Phoenix, MD 21131 D. Thomas Streett/Son 20b. Place of Disposition (Name of commetery, cremejory or other plece)
Dulaney Valley Memorial
Gardens 20a. Method of Disposition May 18, 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility 60 Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

physicien and s the burlei-transit certificata be assecuted

8 for use as

signed by the a

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director; p

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Be Completed

Certification: To

Medical

68760

Box (

P.O.

Records,

of Vital

Division

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

than "natural", or items 23s or the Medical Exercises must be re-

permit. Pages 1 and 2 should be filed within 72 hours effar of Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or hem eny injury or other traumatic event, the Head and another pages.

Baitimore, Maryland 21215-0020

the Maryland r 28a-f ahow I notified at

deeth

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

		Ondo, ond Dodin
a.	CONGESTIVE HEART FAILURE Due to (or es a consequence of):	week
b	ACUTE MYO CARDIAL IN FARCTION Due to (or as a consequence of):	I wee x
C	Due to (or es a consequence of):	
d	Due to (or es a consequence or).	

YORK RD TUWSONMOZIZOG

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manper of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 16 Rev 6/95

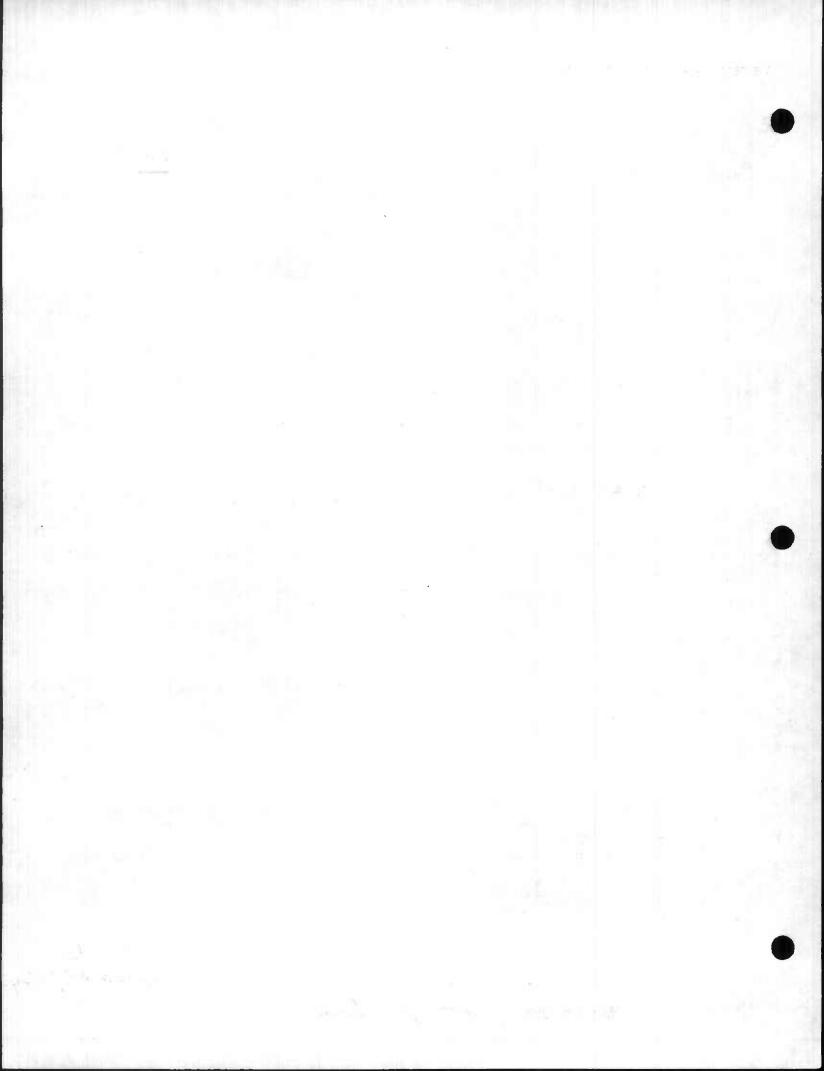
31. Date filed (Month, Day, Year) MAY 1 8 1999

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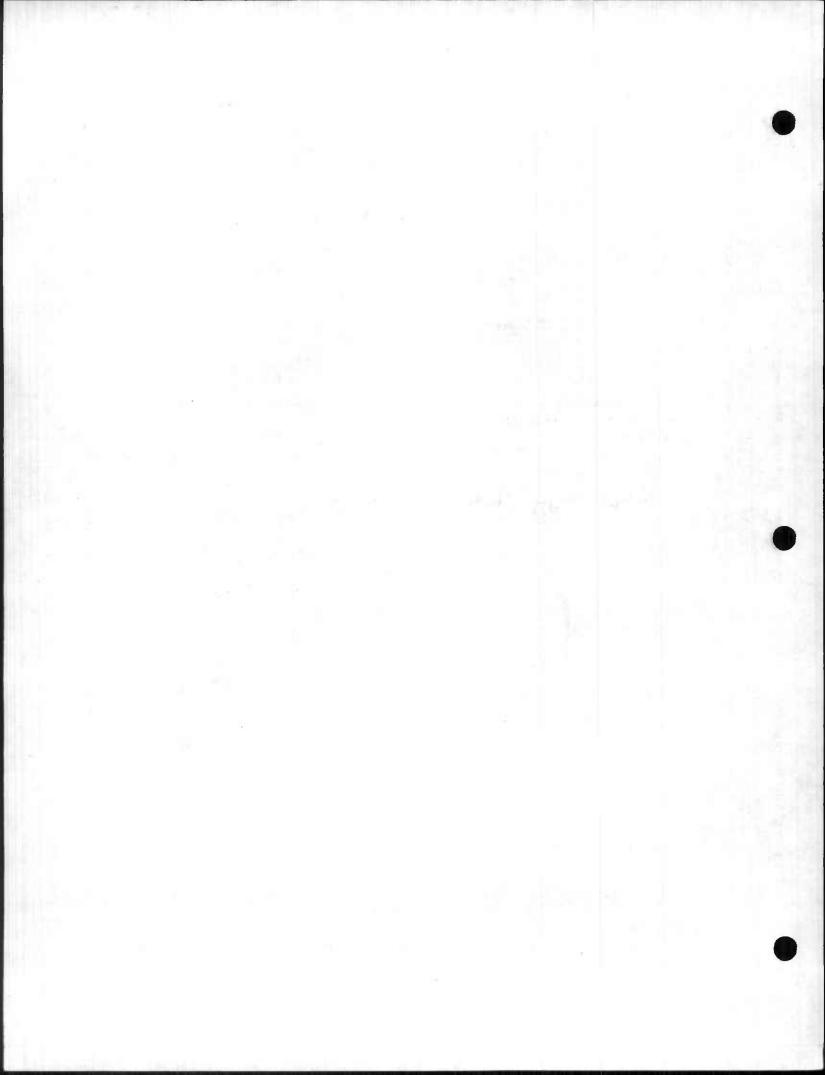
32. Registrar's Signature

LIOMOS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



	Certificate of Death	Reg. No.	99 15924		
ysician Medical	1. Decedent's Name (First, Middle, Last) Antoinette E. Saverino	2. Date of Death Month Day May 16, 1	Day Year 16, 1999 9:00AM 4c. County of Death		
aminer	4a Facility Name (If not institution, give street and number) 3300 Benson Avenue Apt 101 4b. City, Tow Balti				
eral ctor	5. Social Security Number 220-05-5644 6. Sex 1 Months Deys Hours 89 Yrs. 89 Yrs. 6. Sex Months Deys Hours	Min. 8. Dete of Birth Of Month, Day, Year) 24, 190	9. Birthplace (State or Foreign Country) Maryland		
neral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits		
ctor	MD Baltimore		100 kyes 2 □ N		
Director	10e. Street and Number 10f. Zip Code	10g. Citize	on of What Country?		
by Funeral	3300 Benson Avenue Apt 101 11. Marital Status 1 □ Never Married 2 □ Merried 3 ₺ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ₺ No If Yes, Give Year or Detes: 1 □ Yes 2 ₺ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	Black, White, etc.		
Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker	of working	d of Business/Industry Home		
9	17. Father's Neme (First, Middle, Last) 18. Mother	's Name (First, Middle, Maiden St erine Reina			
To	19a. Informant's Name/Relationship (Type, Print) Antoinette C. Manning-Daughter 19b. Mailing Address (Street and Number 28 Summerfield Roa				
	20a. Method of Disposition 1 \(\Delta \) Burial 2 \(\Delta \) Cremetion 3 \(\Delta \) Removel from State 4 \(\Delta \) Donation 5 \(\Delta \) Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Loudon Park		ation - City or Town, State timore, Maryland		
Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 144 PERT SUM SUM SUM SUM SUM SUM SUM SUM SUM SUM	12,310	Interval Between Onset and Deeth FEW MAN		
hysic	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	44.0	Did tobecco use contribute to the cause of de		
Completed by P	DIABETTS MELLINS	24a. Wes an eutopsy performed?			
		1 □ Yes 2-2	No 1□Yes 217No		
Certification: To Be	examiner?				
edical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deet and menner steted.	place, end due to the cause(s) an occurred at the time, date and p	nd menner as stated. plece, and due to the cause(s)		
Me	29b. Signature and title of certifier 29c. License number		signed (Month, Day, Year)		
)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTING L. COMMERTORD MO 5411 800 FRE	EDERICK RD	21229		
State gistrar	31. Date filed (Month, Day, Year) MAY 1 8 1999 Service G. Signature MAY 1 8 1999				



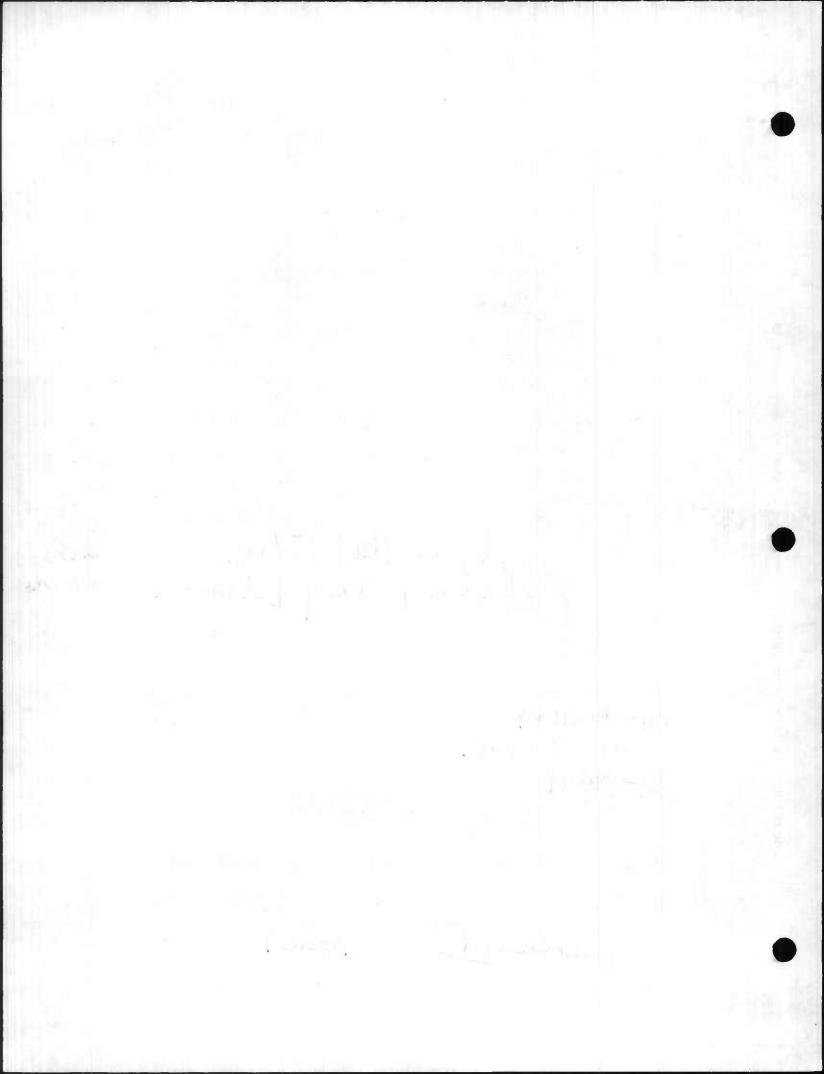
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** CATHERINE M. SWEENEY MAY 14, 1999 7:00 AM /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner COLLEGE MANOR NURSING HOME LUTHERVILLE BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1 M XX 056-07-4420 Director NEW YORK 12-29-1906 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD. N/A BALTIMORE CITY XXYes 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berrie 23a or must be 324 TUNBRIDGE 21212 ROAD U.S.A. Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ather 1 ☐ Yes XX No 1 Never Merried 2 Married natural, or 21215-0020 1 ☐ Yes XX No Specify: WHITE Specify: P Widowed 4 □ Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME YEAR permit. Pages 1 and 2 should be fin Department of Health and Mental Hy important: If Item 27 is marked any injury or other 1s marked 2000s. Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be MATTHEW S. McGONIGLE MARY **AGNES** O'BRIEN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SHEILA S.PETER (DAUGHTER) 6436 BLENHEIM ROAD, BALTIMORE, MARYLAND, 21212 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete XX Burial 2 Cremetion 3 Removal from Stete DULANEY VALLEY M.G. 5-17-99 TIMONIUM, MD. 21093 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
HENRY W.JENKINS AND SONS COMPANY 21. Signeture of Funerel Service Licensee ull 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Fine) diseese or condition resulting in deeth) Examiner sas Examiner yeans ician and burial-transit certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es a cophysician s the burial Box 68760. Physician/Medicai Due to (or as e consequence of): 950 P.O. Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown No þ Records. should 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 hes omente 1 Yes XX No certificate 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes XX No Other XX Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Division of 28a. Dete of tnjury (Month, Dey Year) 27. Menner of Death XX Neturel 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Attanding 5 Pending death. investigation 1 Yes 2 No 2 Accident after deati 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Pleca of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 6 4 Homicide ò 24 hours a Funeral C XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only 29c. License number 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) D2516 MAY 14,1999 of person who completed cause of deeth (Item 23a) (Type, Print) 30. Name end add

State Registrar 31. Dete filed

HORN, M.D., 10755 FALLS ROAD, LUTHERVILLE, MARYLAND,

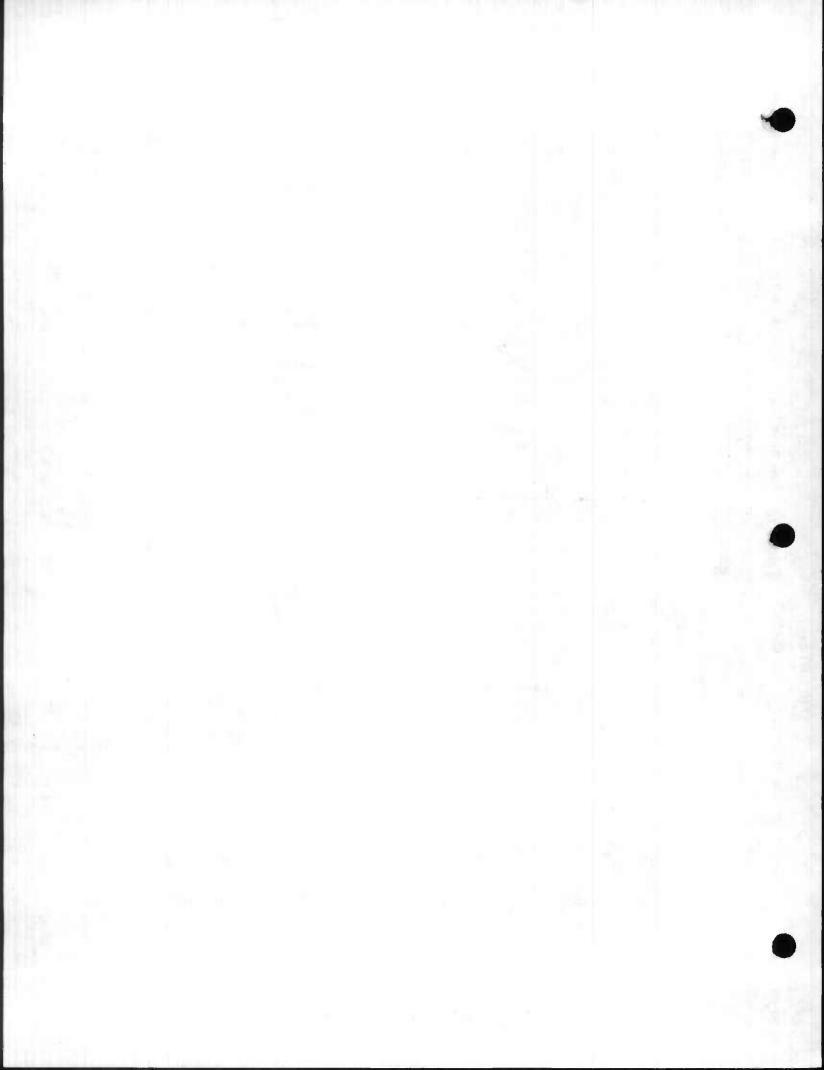
G. Sports



State of Maryland	/ Department of	of Health	and	Mental	Hygiene
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day **Physician** JOSEPH THOMAS SYDLIK 4b. City, Town, or Location of Death 1999 08:00 AM /Medical 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner FRANKLIN SQUARE BALTIMORE BALTIMORE If Under 1 Yaar | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□ F Yes 65 219-30-1249 Feb 20,1934 Director MD Usual Residance of Dacedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits man be notified at 1 No 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 급 USA 1407 LANCELOT DRIVE 21237 Funeral Hema 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 220 No If Yas, Giva Yaer or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. filed within 72 hours after 1 Nevar Married Married Baltimore, Maryland 21215-0020 natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) WESTERN ELECTRIC 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Peges 1 and 2 should be innent of Health and Mental Innert: If Itam 27 is marked or KATHERINE IGNATIUS SYDLIK KMIOTEK 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 LANCELOT DRIVE, BALTIMORE, MD 21237 REGINA SYDLIK 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition Data cemetery, crematory or other place) Burial 2 Cramation 3 Removel from State permit. Pege Department of Important: If any Injury or once. ST. STANISLAUS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) May121999 BALTIMORE , MD 21. Signature of Funerel Service Licensee 22. Name and Address of Facility
KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE, BALTIMORE, MD 21222 acyonousho 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Physician Due to (or as a consequence of): /Medical tmmediate Cause (Final diseasa or condition rasulting in death) Examine Examiner physician and the burial-transit Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Cause (Diseasa or Injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown bengis d be det þ Records, been si 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No of Vital 25. Was case refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ TOOA this funeral 27. Menner of Death 28e. Deta of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division or Attanding 1 [dNetural 5 Panding Invastigation n 24 hours after deeth.

• Funers! Director: Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28a. Place of Injury - At home, ferm, streel, factory, office building, atc. (Specify) 4 Homicide Hospital edicai 29a. Cartifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. To the Hosp within 24 ho To the Fune completely fi 2 Medicat Examiner: On the besis of axamination and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner stelled. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and titia pricertifier 017148 5-18-95 30. Nema and addrass of parson who completed cause of deeth (Item 23a) (Type, Print) 31. Data filed (Month. Day, Year) 32. Registrar's Signatura State south Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) Dey V2_ Month 1999 Z45 PM William Small 4s Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore, MD Baltimore City Good Samaritan Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | 1932 5. Social Security Number 249-46-6816 Birthplece (State or Foreign Country) 7. Aga (In yrs. lest birthdey) 1 XXX 2 □ F Yrs. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore n/a Ves 2□No 10g. Citizen of Whet Country? 10e. Street end Number 5506 Sagra Road 10f. Zip Code 21239 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Dates: Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian 11 Maritel Status Bleck, White, etc. Specify: Black 1 Never Marriad 2 Nerried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 18e. Decedeni's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Baltimore City .Elementary/Secondary (0-12) Collega (1-4or 5+) Dept. of Transportation Chauffeur 10th 17, Falhar's Nama (First, Middla, Last) Joseph Small 18. Mothar's Name (First, Middla, Malden Surnama) Daisey Knox 19a. Intorment's Neme/Reletionship (Type, Print) Wife Pauline Small 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) 5506 Sagra Road Baltimore, MG. 21239 20b. Place of Disposition (Nama of cemetary, crametory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Surial 2 Cramation 3 Removal from State May 22 Woodlawn Cemetery Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specty) 22. Name and Address of FacilityNutter Funeral Homes, Inc. 21. Signeture of Funeral Service Lie 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pet1, Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errast, shock, or heart feilure. List only one cellse on each lina. Approximata Intervel Between Onset and Deeth Immediate Ceuse (Final disaase or condition resulting in deeth) . Acute Renal failure 1 dysphajia ropharyngea Recurrent Strokes Due to (or as e consequence of) Atherosclerotic Cardiovascular disease 23b. Did tobacco use contributa to the ceusa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 □ Probably 4 □ Wnknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy tindings available prior to completion of cause 24e. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

> the signed by the

certificate Physician:

this funeral

n 24 hours after death.

Me Funeral Director: After the pletely filled in by the funeral

within 24 hor To the Fune completely fi

Completed by

Be

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Certification:

Medical

Division of Vital Records, P.O. Box 68760

The

or Attending

attending physician and for use as the buriel-transit law requires thet the deeth certificate be executed

Physician

/Medical

Examiner

10e. Stete

Funeral

Director

28a-f show

Director

Funeral

à

Completed

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Modical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Heelth end Mental Hygiene.
Important: if frem 27 is marked other than "natural", or frems 23a any injury or other traumatic event, the Medical Examine manal once.

the Marylend

Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in daeth) Last

Hypertension

Diabetes Mellitus

25. Wes case reterred to medical examiner? 1 Yes 2 No 27. Menner of Deeth

MAY 1 8 1999

28e. Date of Injury (Month, Dey Year) 5 Panding invastigation

28b Time of

28a. Place of Injury - At homa, tarm, streat, factory, office building, atc. (Specify)

28c. injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29e. Certifier (Check only one)

1 Neturel

2 ☐ Accident

3 ☐ Sulcide

4 - Homicide

12 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and mennar as stated.

2 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, daeth occurred at the time, date end piece, end due to the cause(s) end mannar stated. 29d. Date signed (Month, Dey, Year)

29b. Signature end title of certified

6 Could not be datarmined

29c. License number

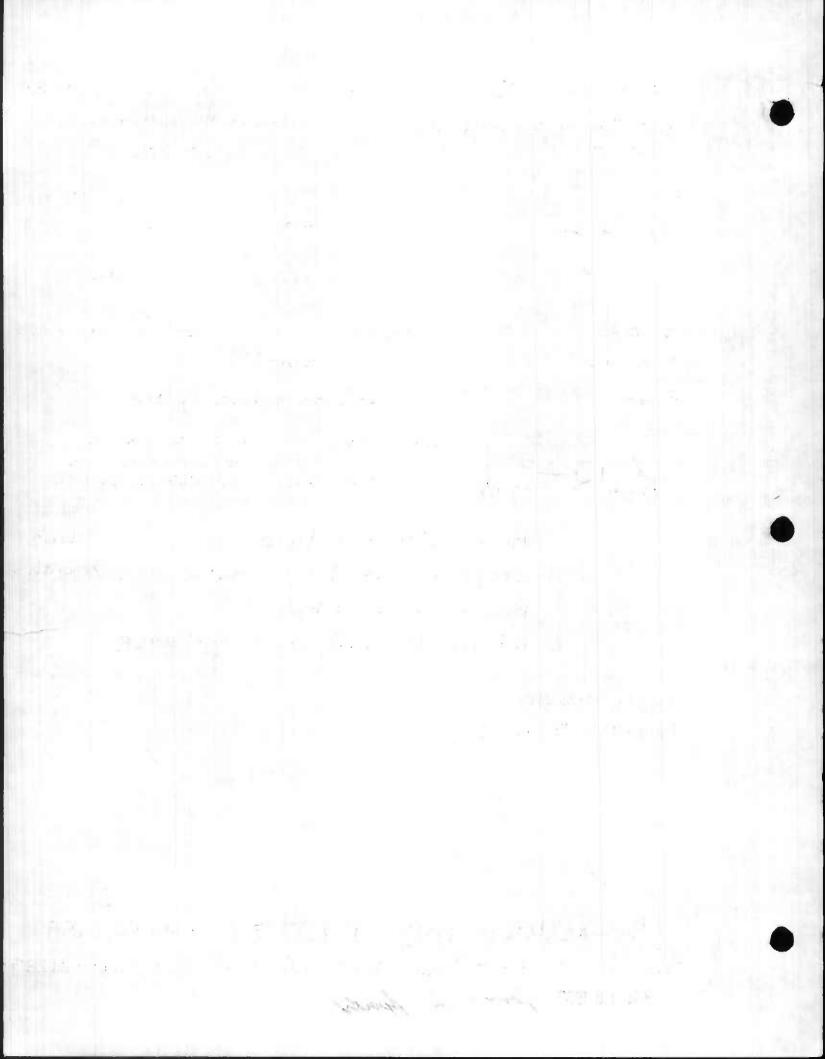
May 12,1999

30. Neme end eddress of person who completed cause of death (Itam 23e) (Type, Print)

5601 LochRaven Blud, Baltimore 21239 Thomas S. Wilson MC 31. Dete filed (Month, Dey, Yeer)

Registrar

32. Registrer's Signeture



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene PER MEO G771 5-18-99 WR. Certificate of Death ITEM: #10 1 Decedent's Name /First Middle Last) 2. Date of Death 3. Time of Deeth **Physician** 1:00pm MAY /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GERIATRIC CENTER JOHNS HOPKINS N/A 7. Age (In yrs. last birthday) | Hunder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (Stata or Foraign Country) 5. Social Security Number **Funeral** 1 M 25 74 Yrs. November 9, 1924 219-10-2548 Director Maryland Usual Residence of Decedent with the Maryland r 28a-f show 10a: State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE COLGATE -1 X Yes 20 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? *naturel", or items 23s or 21224 7208 6046H ST. USA permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a ence, in any Injury or other traumatic event, tra Medical Example manages. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Biack, White, etc. 1 ☐ Yas 2(文 No If Yes, Give Yaar or Dates: 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowad 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Ruth C. Sullivan Henry Freund 10 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
7208 Gough Street Baltimore, Maryland 21224 19a. Intormant's Name/Relationship (Type, Print) Ruthann Holbrook/Daughter 7208 Gough Street 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 5/17/1999 Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 12hours ON Examiner Due to (or as e consequence of): Examine ed by the attending physicien end detached for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were eutopsy tindings available prior to should t 24a. Was an eutopsy performed? Completed completion of cause of deeth? page 2 300 1 Yes 2 No 1 ☐ Yea 2 ☐ No certificate or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Naturai 5 Pending a Euneral Director: Af bletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Sulcide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifie edical (Check only one) To the Pwithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptific

State Registrar

DHMH 16 Rev 6/95

MAY 1 8 1999

30. Name and address(ot person

31. Date tiled (Month, Day, Year)

32. Registrar's Signature

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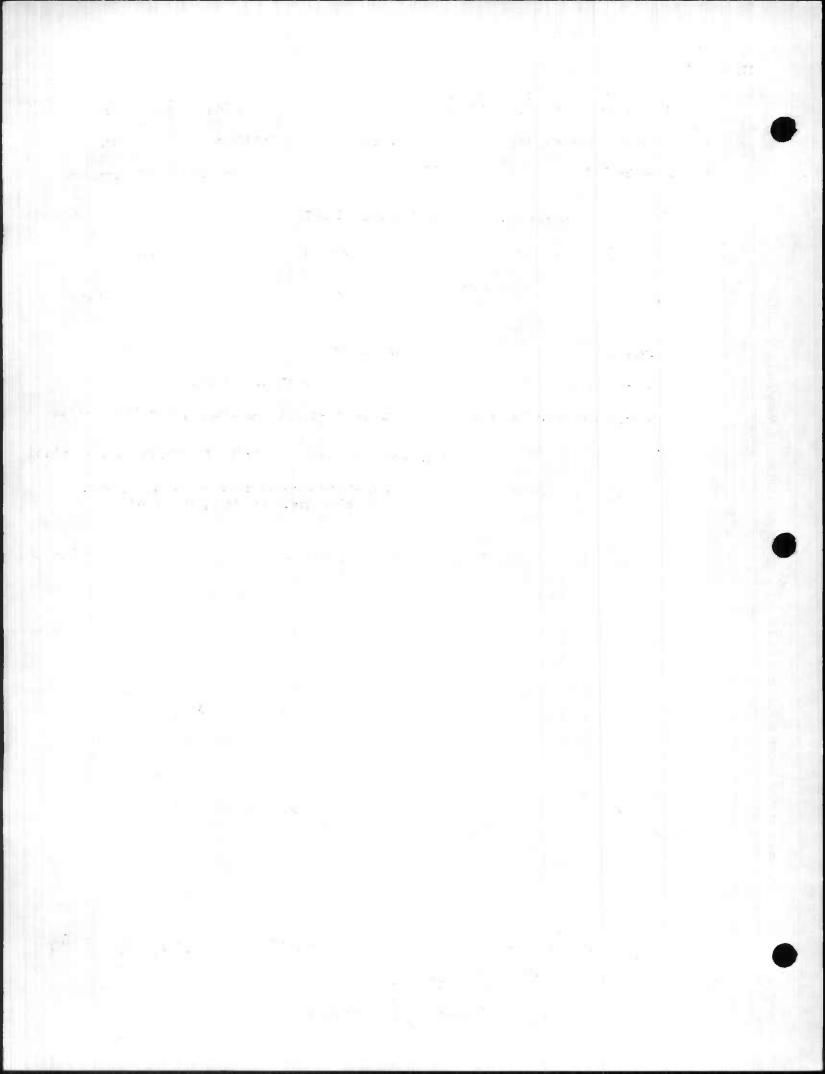
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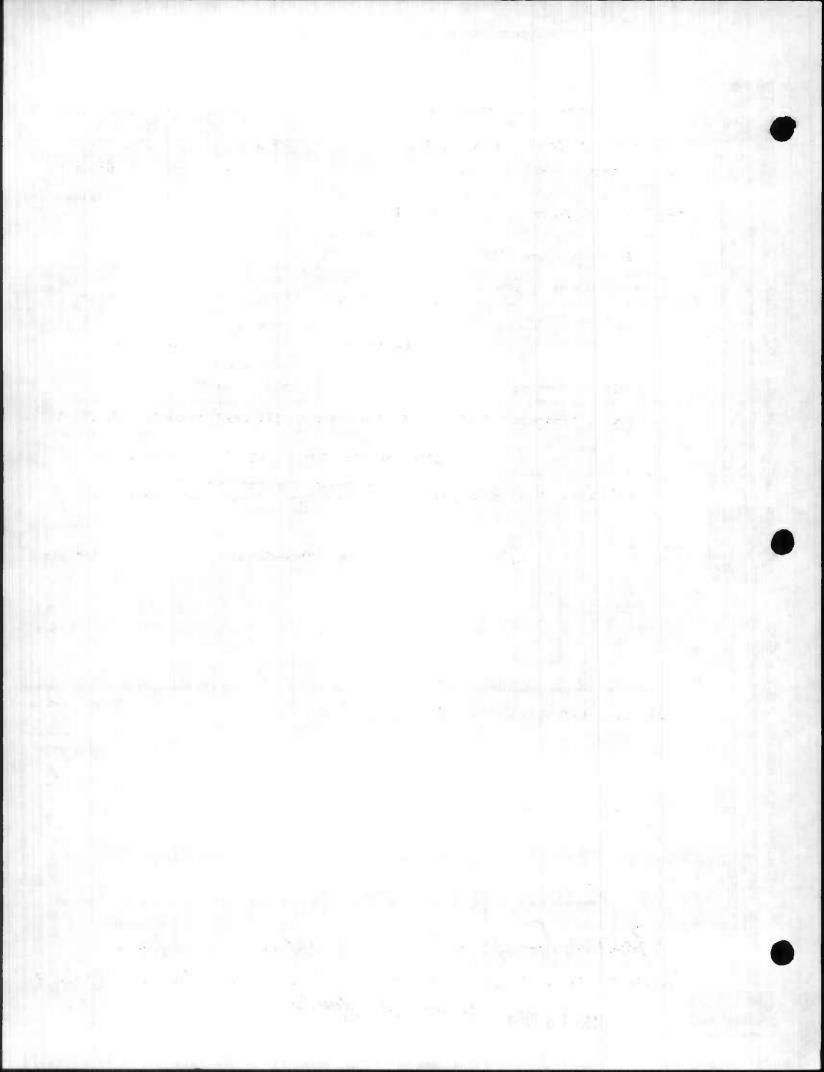
4940 Eastern Blud.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thompson MAY 1999 Kenneth W. 13 11:19 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs BALTIMORE If Under 1 Year 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1√DM 2□ F Months Days Hours Min Yrs. 3-6-1923 Virginia 225-22-0543 76 Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location marked other than "naturel", or items 23a or 28a-f aho immite event, me Medical Examinar must be notified at Phoenix Maryland Baltimore 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21131 U. S. A. 3519 Stansbury Mill Road death Funeral Z 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 111 Black, Whita, etc. 72 hours after 1 Yes 2 No 1 ☐ Never Married 3 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HOMIPSON, Elementary/Secondary (0-12) College (1-4or 5+) Engineer Koppers Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Pages 1 and 2 should be in nent of Health and Mental I Weddle Lala Donald W. Thompson 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health of Item 27 i 3519 Stansbury Mill Road, Phoenix, Md. 21131 Mrs Mary C. Thompson (Wife) Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) = 6 Department of Important: If any injury or 5-15-99 Towson, Maryland Hilltop Service Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, S. 1050 York Road, Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final HORTIC 12 170048 disease or condition resulting in death) UNED **Examiner** Due to (or as a consequence of) Examiner physiclan and s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown PULMONAR by 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? i cartificate has t 1□ Yes 21 No 1 Yes 2 No director, 86 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 28e. Date of Injury (Month, Day Year) Hospital or Attending P. 124 hours after daath.
 Funeral Director: After ti 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dele and place, end due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steled. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medicai (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifiar 29c. Licanse number 620 and address of person who completed/cause of death (Item 23a) (Type, Print) PISOLUIX PAPERMIL Rd WIEGERELD MD 3346 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sperse. Registrar

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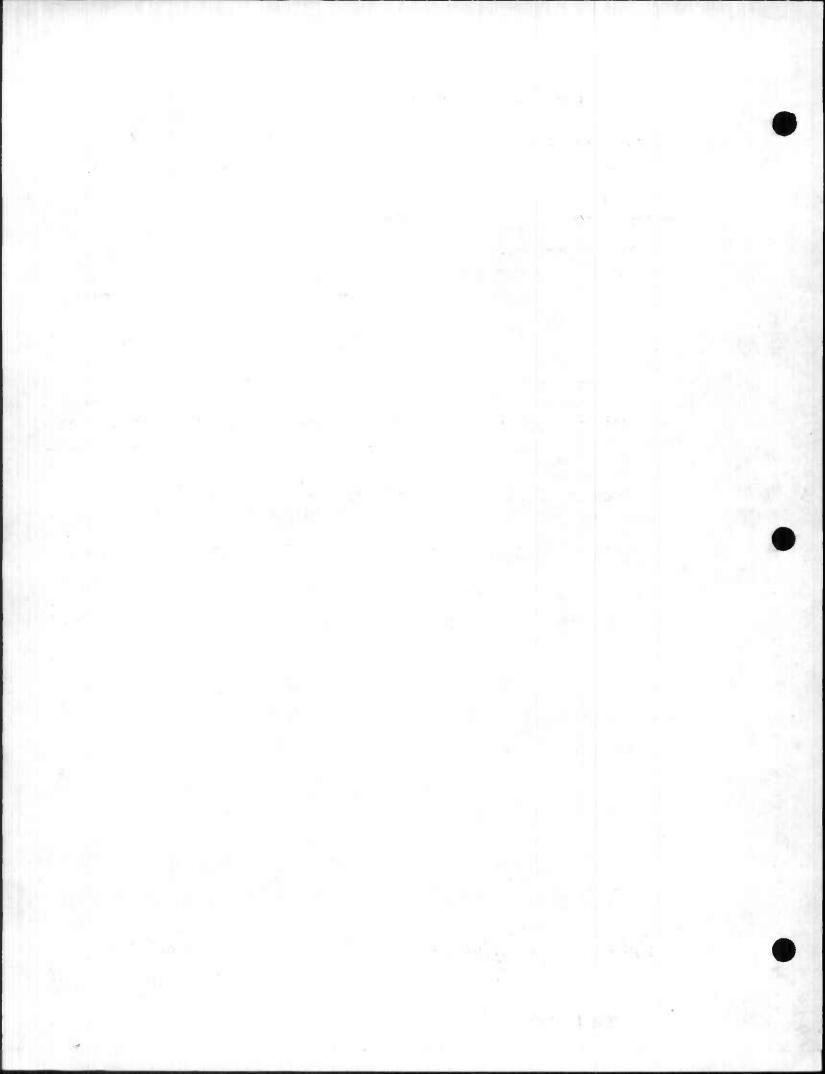
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	Decedent's Nama (First, Middla, La	st)	Certifica	ate of	Death	2. Data of Deat	eg. No.		3. Time of Death
•	Marjorie		nello			Month OS	19 19	70ar 799	3:50 AM
	4a Facility Nema (If not institution, giv	a street and number)			4b. City, Town, or Lo		4c. County	of Death	31-011.1
Kallilliet	Wesley Home,]				Baltimo	re	N	/A	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burist-transit or the funeral director, page 2 should be detached for use as the burist-transit or the funeral director, page 2 should be detached for use as the burist-transit or the funeral director, page 2 should be detached for use as the burist-transit or the funeral director. To Be Completed by Physician/Medical Examiner To Be Completed by Physician/Medical Examiner	5. Social Security Number 6. S			der 1 Yaar	If Undar 24 Hrs.	8. Data of Birth (Month, Day,		,	laca (Stata or Foreign
	578-12-5678 Usual Rasidance of Decedant	□M 3√√F 85	Yrs. Month	Days	Hours Min.	6-15-19		Mary	land
10	10a. Stata 10b. County	10c. City	, Town or Location					1	0d. Inside City Limits
lo lo	Maryland N/A		Baltimore						1 Nas 2 No
9	10e. Street and Number			Zip Code		10	Dg. Citizen of V	Vhat Coun	try?
ms 23a or ms 23a or meral Dir	2211 W. Roger		2120	09		U.	S. A.		
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2	15. Decedent's Ed	ducation	16a. Decedent's U	sual Occu	pation	. 1	16b. Kind of Bu	sinass/Ind	dustry
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E	12	College (1-401 34)	Homema	ker			Own 1	Home	
Se C	17. Fathar's Nema (First, Middla, Last,				18. Mother's Nem	e (First, Middle, N	Aaiden Surnem	a)	
0	Henry Rosin Ethel M. Carpenter								
	19a. Informant's Name/Ralationship (Type, Print)	19b. Meiling Addr	ass (Stree	t and Number or Rur	al Routa Number,	City or Town,	Stata, Zip	Code)
	Mr. Philip J. De	Gele (PR)	3111 W	ellir	ngton Way,	Baldwin	, Marv	land	21013
	20a. Mathod of Disposition	20b. PI	aca of Disposition (/	Vama of		Data 2	20c. Location -	City or To	wn. Stata
	1 № Burial 2 Cramation 3 C 4 Donation 5 Other (Specif	JRamoval from Stata Dul	aney Vall	ey Me	Gards.	5-17-99	Timon:	ium,	Maryland
#	21. Signature of Funaral Sarvice Licer		22. Nama	and Addr	ass of Facility				
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EX	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents	CERHBRO WA		10	01×105				VIM-OC
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sicia	Part II. Other significant conditions of	ontributing to death but not rasu	iting In the underlyin	g causa d	iven in Part I.	23b. Did to	bacco uss co	ntribute to	the cause of death?
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y P	CHRONC OBSTR	uctive puin	IONAGY	DI	7 FATE				7
2	1/2 11.0 11.00	DICIMIE	,				n autopsy	24b. Wa	are autopsy findings allable prior to
olet	ALZHOMPRS	DISTALE				perform	ileu i	CO	mplation of causa death?
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Be C	25. Was casa referred to medical				28. Place of Deat				74110
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tloi	1 Natural 5 Pending invastigation		Injury M		ork?]Yas 2 No				
fica	3 ☐ Suicida 6 ☐ Could not b	e 28a. Place of Injury - At ho	ma, farm, straat, fac	lory, office		28f. Location (St		er or Rura	I Routa Number,
ert	4 Homicida datamined	building, atc. (Specify)			City or Town	n, Steta)		
Medical Certification:	29a. Certifier (Check only one) (Check only one)	ysician: To the best of my knowniner: On the basis of axaminati and manner stated.	vledga, daath occurr ion and/or invastigat	ed et the t	ima, data end place, opinion, daath occur	and dua to the ce red at tha tima, da	ouse(s) and me ata and placa,	ennar as si and dua to	tated. o the causa(s)
X	29b. Signature and title of certifier	and mainter stated.		29c. Licen	isa number	25	9d. Data signe	d (Month,	Day, Year)
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	31. Data tiled (Month, Dey, Year)	32. Registrer's Signet		UCK.	1410	PHUIO	TIME	. 2	1207
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** : SOPM stan leu /Medical 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HURCH BALTIMORE If Under 24 Hrs. N/A HOME HOSPITAL If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Yrs. 216-28-7289 10 MD **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD NIA BALTIMORE 288-1 2 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2 terns 23a KOUNDVIEW KOAD USA 602 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Merried 2 Married natural, or 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA JEWLER GED 27 is marked other r traumatic event, I Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be IHORNTON EVELYN HERBERT JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KOUNDVIEW or other tr MITSUKO IHORNTON BALTO MD. altimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-20-99 CROWNSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) nlury CEMETERY 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREÉNE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MO. 21229 23a. Pert1. Enter the threase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hem favore. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medicai Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): 68760 Physician/Medical the Due to (or as a consequence of): Box use P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed l Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 2/1 No 1 ☐ Yes 2 No certificate Vital al or Attending Physician: The safer death.

It Director: After this certificated in by the funaral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Inpatient 2☐ ER/Outpatient 3☐ DOA of Certification: Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D completally filled Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifies, 29c. License number 29d. Date signed (Month, Dey, Year)

BROADWAY

BALTIMINE

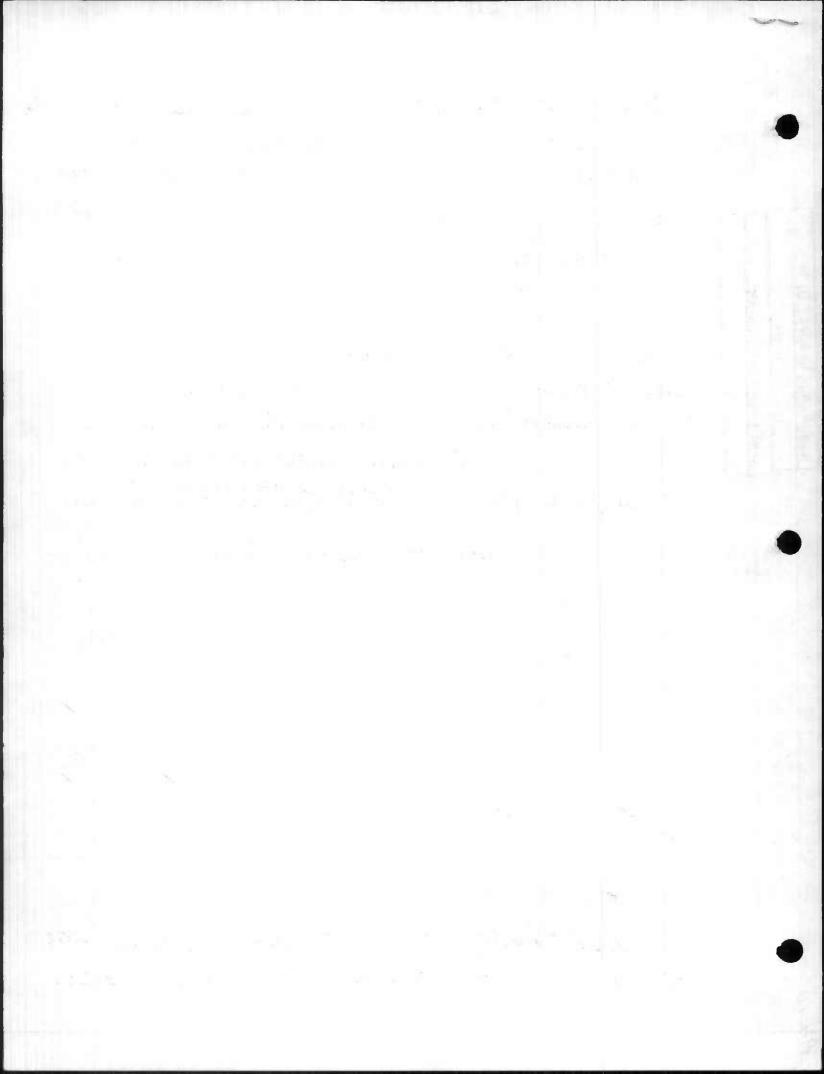
State Registrar

31. Date filed (Monti

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

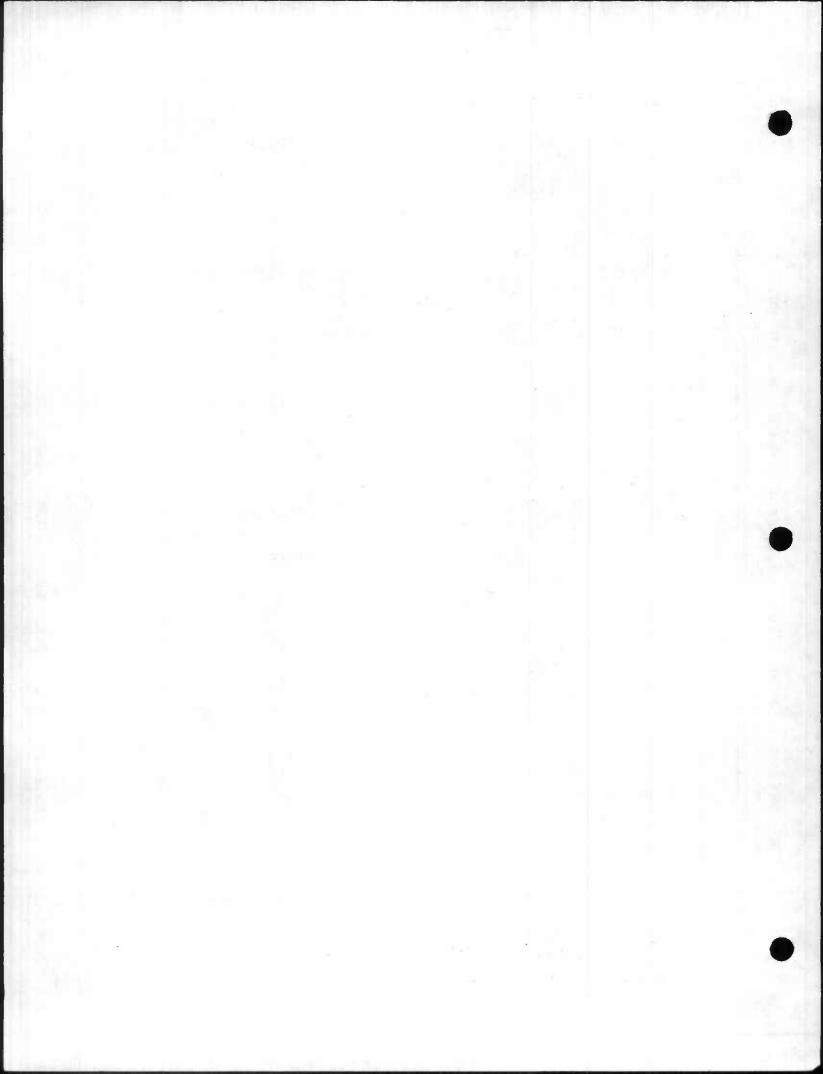
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32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

	1 December 1/2 Name (First Middle Least)		Certificate of	Death	2. Date of Dea	eg. No. 99	15932	
Physician		Decedent's Name (First, Middle, Last) JOHN DAVID STONE, JR.				Day Y	year 999 2:23 pm	
/Medical Examiner	4a Facility Name (If not institution, give stre	4a Facility Name (If not institution, give street and number)					Death Death	
4	6122 CAMELBACK I			COLUMBIA		HOWA		
Funeral Director	5. Social Security Number 048-22-8977 Usual Residence of Decedent	2□ F 7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B Date of Birth (Month, Day Dec . 19	Year) 1929). Birthplace (State or Foreign Country) CT	
fanyland above	10a. State 10b. County MD Howard	10c. City, Town				TP	10d. Inside City Limits 1 ☐ Yes 2√ No	
death with the Maryland ma 23e or 28e-f show creat be notified at neral Director	10a. Street and Number 6122 Camelback La	ne	10f. Zip Code 2104	5	1	10g. Citizen of What Country?		
urs after	11. Maritel Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U,S. Armed Forces? 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1952-71	13. Was Decedent of I It Yes, specify Cub		ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
72 ho natur	15. Decedent'a Educet (Specify only highest grade of Elementary/Secondary (0-12)	on 16a. In the completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire Col. Us Ar	during most of work d)		16b. Kind of Busin		
Hygie Hygie of the The The The The The The The The The T	17. Father's Name (First, Middle, Last)	2 116.	COI. US AL	18. Mother's Nam	-		-	
ould be fill Mental H mrked off atic ever	John D. Stone, Sr.			Bessie	M. (Lewis)			
and 2 should be file aith and Mental Hy 27 is marked oth or treumatic event	19a. Informant's Name/Relationship (Type, Virginia Stone (W		Mailing Addrass (Street 22 Camelbac				ate, <i>Zip Cod</i> e) 045	
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Departm Departm Importa eny Injui	21. Signature of Funeral Service Licenses	10 85	22. Name and Addre Witzke Fu	ess of Facility neral Hon	mes, Inc	•		
Physician /Medical	23a. Part1. Enter the disease, or complicat shock, or heart tailure. List only one of Immediate Cause (Final disease or condition		ot enter tha mode of dyi		or respiratory arr	umbia, M	Approximate Interval Between Onset and Death	
Examiner	resulting in death) a	Metastatic No Billing Obstruc	onsequence of):	IT TOOKS C	www		6 1/24rs. Hweek	
filicate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	Due to (or as a co			1014113			
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nat the death cert d by the attending setached for use Physician/M	Part II. Other significant conditions contrib	uting to death but not resulting in	the underlying cause gi	ven in Part I.	23b. Did to	bacco use contr	ibute to the cause of death?	
					1 24	es 2□No 3	Probably 4 Unknown	
aw requisite been 2 should					24a. Was a perfor		24b. Wera autopsy findings available prior to complation ot ceuse ot death?	
- 4 0					1□ Y	es 25 No	1 ☐ Yas 2 ☐ No	
iclen: certific ector	25. Was case reterred to medical examiner?	nital:	0	26. Place of Deather:				
, Z 50 5	1 Yes 2 2 No	1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. Ti	me of jury 28c. Inju	4 U Nursing H	ing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Suiside 6 Could not be	NO CO. Discontinuo Albarra (a. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.			28f. Location (S City or Town	or Rural Route Number,		
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 16 Certifying Physicial (Check only one) 2 Medical Examiner:	n: To the best of my knowledge, On the basis of axamination and and manner stated.	daath occurred at the ti	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manr ate and place, an	ner as stated. d dua to the cause(s)	
To the within To the compl	29b. Signature and title of certifier	(1	29c. Licens	se number	2	9d. Date signed (Month, Day, Year)	
10	Michilas W- Kens	relubios	D3	8509	1	may 14	1949	
10	30. Nama and addrass of person who comp NICholax Lali Rout	gelakos 11065 U	ittle PATU,	Xeut Phin	Colun	chia m	D 21044	
State Registrar	31. OMPAY (MONE 019991)	32. Begistrar's Signature	Sparker					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month MAY 4:14 AM **Physician** Jeffrey M. Taylor /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL BALTIMORE AGNES if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 XM 2 F 215-96-8839 Yrs. 20 July 23, 1978 Maryland Director Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Howard Columbia 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 10f, Zip Coda 10g. Citizan of What Country? r hams 23a or niner must be n 9351 Sharp Antler 21045 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, atc. Black 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16h Kind of Rusiness/Industry Elementery/Secondary (0-12) College (1-4or 5+) Student College 18. Mothar's Nama (First, Middla, Maldan Sumema) 17. Fathar's Nama (First, Middla, Last) should be Mental Robert L. Taylor Dolores Valentine 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Robert L. Taylor (Father) 9351 Sharp Antler, Columbia, MD 21045 Hem 27 i 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Pages ₩ Buriai 2 Cramation 3 Ramoval from Stata Columbia Memorial Pk. 5/18/99 Clarksville, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 21. Signature of Funarai Sarvice Licensas Lemn 5555 Twin Knolls Road, COlumbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feiture. List only one cause on each line. Approximete intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in daath) ASYSTOLE Examiner RTIC VALVE ENDOCARDITIS Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseese or injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Part ft. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? CONGENITAL HEART DISEASE 1 Yes 2 No 3 Probably 4 Unknown by PATENT DUCTUS ARTERIOSUS 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of deeth? -COARCTATION OF ADRIA 1 Yas 2 No or Attending Physician: 25. Was case referred to medical axaminar? Be 26. Placa of Deeth (Check only ona) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 2 1 Yes 2 No 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding 1 Natural 1 ☐ Yas 2 ☐ No Invastigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida 24 hours aft Funeral Di 29a. Certifier tercentifying Physician: To the best of my knowledga, daath occurred et tha time, deta end place, and due to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifiar P-12704 May, 14, 1999 Loman

State Registrar 31. Data filed (Month, Day, Year)

MAN 1 8 1000

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30. Nama and addrasa of person who complated causa of daeth (Item 23e) (Type, Print)

KORZAN

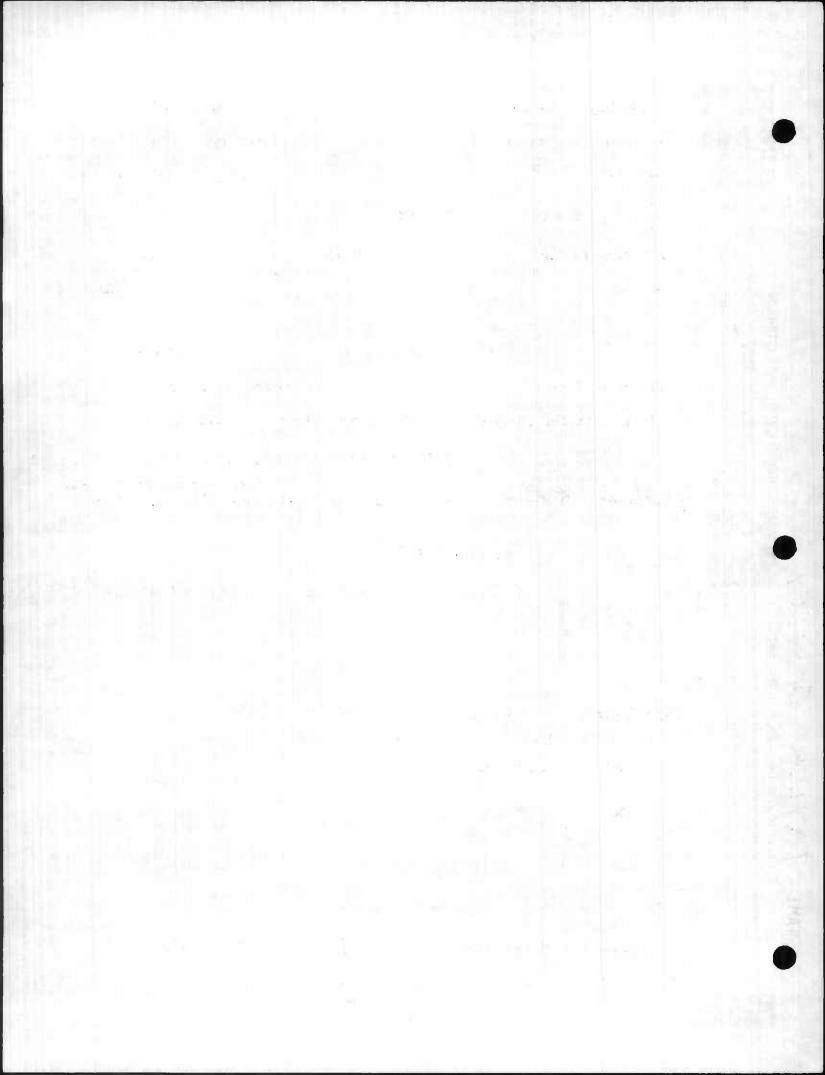
32. Ragistrar's Signatura

CAION

AVE, BALTIMORE MD 21229

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020



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	Please	Type or Prin	t In Bla	ck Inc	lelible Inl	c. Assu	ıre A	II Coples	Are Leg	lble.	
		State of Ma	ryland /		rtment of tificate of			Mental Hy	giene 9	3 1	5934
				Cer	illicate of	Deali			Reg. No.		
1. Decedent's Neme WARN	(First, Middle, L	TEUF	ER	,				2. Dete of D	Dey	Year 99	3. Time of Death
4a Escility Name (If	not institution a	ve street end number)				4b. City. To	own, or L	ocation of Dea		y of Deeth	
		tric Cent	er			*		imore	n/		
5. Sociel Security Nu 217–34–5		Sex 7. Age 15x M 2□ F	(In yrs. last t	Yrs.	If Under 1 Yea Months Deys		24 Hrs. Min.	8. Dete of Bi (Month, D Jan.	rth ey, <i>Year</i>) 1 1937	Cou	plece (Stete or Foreign intry) 'yland
Usual Residence of D	Decedent										
10a. Stete	10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits
Md	Bal	timore			Mi	ddle H	Rive	r			1 ☐ Yes 2 No
10e. Street end Num	ber				10f. Zip Code				10g. Cittzen of	Whet Cou	intry?
137 D	iheral	Drive			212	20			USA	A	
11. Marital Stetus 1 Never Marrie 3 Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes:			/es Decedent of Yes, specify Cu ☐ Yes 2 No			pecify Yes or N Rican, etc.)	0- 14. Re Ble Speci	ck, White	ican Indian, , etc. ite
	15. Decedent's E ly only highest g		16	Sa. Deced	ent's Usuel Occ kind of work don O NOT use retir	upetion e during mos	st of work	king	16b. Kind of E	Business/Ir	ndustry
Elementery/Second		College (1-4or 5-	-)		eelwork				Bet	th St	eel
17. Father's Name (F		1)				18. Moth	er's Nem	e (First, Middle	a, Maiden Sume	me)	
Henry Te		7						Roper			
19e. Informant's Nan	The same of the same		15						ber, City or Town		
Virginia	Teufer	/ wife		13	7 Diher	al Dri	ive	Balt	imore M	a. ZI	220
	Cremetion 3 l	Removat from State	ceme	tery, crem	etory or other p		E /10	Dete	20c. Location	- City or T	
4 Donetion 5			Palky		Cemeter	*		3/99	Ball	rmore	MQ.
21. Signeture of Fun	Tibe	46	Oli	, C	Name end Add	Funer	ral F			0.1	
23a. Part1. Enter the shock, or heert	e diseese, or con feilure. List only	no cations that ceused y use ceuse on each tind	the death. D	o not ente	r the mode of d	/ing, such es	cerdiec	or respiretory	errest,	6.1	Approximete Intervat Between Onset end Deeth
Immediate Ceuse (F disease or condition		Pneumoni	q								24 hours
resulting in deeth)			Due to (or es	e consequ	uence of):						
Sequentially list cond	ditions,	b	Due to (or es	e consequ	uence of):					- 1	

/Medicai

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, it is Medical Exercise must be notified at once.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

Physician Examiner Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be assected within 24 hours state death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Be Completed

Medical Certification: To

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lest

Due to (or es e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

hemiparesis, covering ordery disase. hort failure, insulin dependent diobetes

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy findings evellable prior to completion of cause of deeth?

2 No 1 Yes 26. Place of Deeth (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 No

25. Wes cese referred to medicat examiner? 1 Yes 2 No 27. Menner of Deeth 1 Naturel 2 Accident

5 Pending

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) Investigation

Hospitet:

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. injury at Work? 1 Yes

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier

3 Sutcide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

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D0052104

arde,

16, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

77 moth/ Loo 31. Dete filed (Month, Dey, Year) MAY 18 1999 Hopkins 32. Registrar's Signeture

12th

Henry Teufer

Virginia Teufer / wife

137 Diheral Drive

Parkwood Cemetery 5/18/99 Balitmore

Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year FARRIOR TATUM 1999 3:30 pm ROVENIA MAY 14 4b. City. Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) JOSEPH RICHIE HOSPICE BALTIMORE CITY If Under 1 Yaar 9. Birthplaca (Stete or Foreign 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Aga (In yrs. last birthday) Days 1 M 2KM Months Hours NORTH CAROLINA Yrs 74 SEPT 14 1924 243-24-1665 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits ₩XXYas 2 No BALTIMORE CITY MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 3610 WABASH AVENUE 21215 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yas 2221No If Yes, Give Year or Detes: 1 □ Naver Married 2 □ Married 1 Yas 2 No Specify: Specify: BLACK 3 ☐ Midowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th grade 3 yrs APOSTLE BISHOP 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumeme) EVA CHASEN FARRIOR COY FARRIOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intermant's Name/Relationship (Type, Print) 3237 Dorithan Road, Baltimore, Maryland 21215 Cynthia A. Tatum-Jordan/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Amemation 3 Removal from State 5-17-99 BALTIMORE, MARYLAND METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA Ever 1206 W NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings 24a. Was an autopsy performed? completion of ceuse of death? 1 TYes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical axaminar? 26. Piace of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Dother (Specify) Hogycc 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accidant

the buriel-tren end ettending physician certificate be 80 980 the o á signed t Records, Nes page 2 certificate Vital Physician: director, of this funeral After Attending Division death. efter death Director: filled in by

6 Hospital within 24 hours

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Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

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72 hours efter

should be filed within Hygiene.

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permit. Peges 1 end 2 st Department of Health and Important: If item 27 Is n

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Certification:

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completely

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and line at certifie

LOBEDY

other traumetic event,

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altimore, Maryland 21215-0020

State Registrar

31. Date tiled (Month, Day, Year) MAY 1 8 1999

6 Could not be determined

0.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) valle MI 32. Registrar's Signature

wurd

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

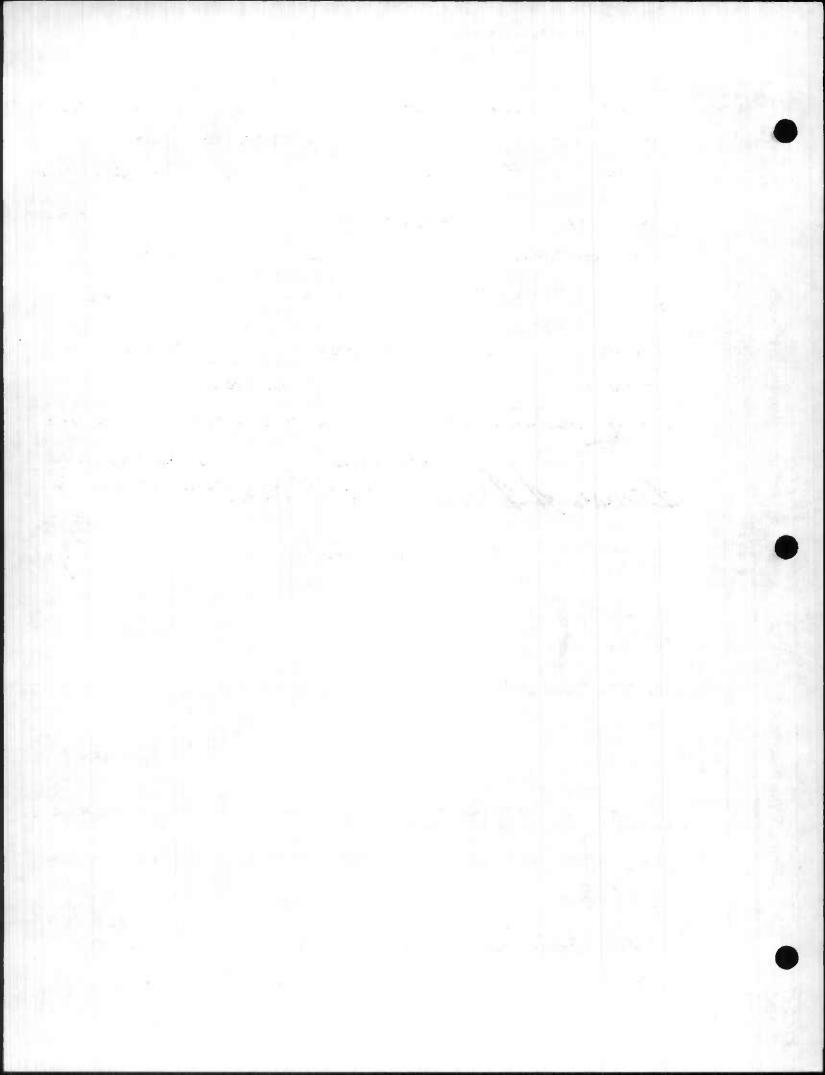
828 N. Eudawst. Ballo Md >1201

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Data of Death 3. Time of Death 1. Decedant's Name (First, Middla, Last) Yaar Month **Physician** Mary hucile Vand 4a Facility Nama (It not institution, giva street and number) Lucile Vandenhrund Mu 1999 9105 Bm 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Carol hutharn Village Oga (In yrs. last birthday) If Under 1 Yaar Carroll Birthpiaca (State or Foraign Country) **Funeral** 1 M 247 F Months Deys 481-16-7303 89 FEB 9, 1910 Director Iowa Usuat Rasidance of Dacedant the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Carroll. Westminster 1 Yas 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 250 Luke Circle, Unit 503 21158 USA Funeral deeth 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yas, Giva Yeer or Dates: 14. Reca - Amarican Indian, Black, Whita, atc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No. If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 11. Marifel Status permit. Pages 1 and 2 should be filed within 72 hours efter a Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examina back. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify à 3 XWidowed 4 ☐ Divorced White Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Coltega (1-4or 5+) Elementary/Secondary (0-12) Fine Arts/Pottery Studio/Teacher 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Sumema) Orla Daniel Nickle Grace Batman 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Retetionship (Type, Print) 15 Sycamore Ave. Easton, MD Sue Loweree/daughter 20b. Place of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Crametion 3 ☐ Removal from Stata Metro Crematory, Inc. 5/18/99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) George E. Mac 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. 97/1 E. MacNabb 21228 299 Frederick Rd. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Batween Onsat and Death Physician Immediata Cause (Final disaasa or condition rasulting in daath) /Medical **Examiner** Due to (or as a consequanca of): Examiner Ixhemei attending physician and for use as the bunal-transit the death certificate be executed Sequentietly list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Vasal þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate hes b lirector, page 2 si 2 No 2 No 25. Was casa rafarrad to medicat examiner? Be 26. Placa of Daeth (Check only ona) To Hospitel: Other: Oth 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27 Mennar of Death 28c. Injury at Work? 28b. Tima of Certification: After Neturel 2 Accident or Attending 5 Panding invastigation after deeth. I Director: Aff od in by the fu 1 Yas 2 No 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 6 Could not be detarmined 3 ☐ Suicida 28a. Plece of Injury - At home, ferm, sfreet, fectory, offica building, etc. (Specify) 4 Homicide • Funeral Dire letely filled in b Hospital Certifying Physician: Young ensit of my king 29a. Certifier de the course of the time, date and place, and due to the couse(s) and manner as stated To the Hosp within 24 hou To the Fune completely fi edical stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 17th 1999 30. Name and address of person why compl d cause of ceath (Item 26a) (T pe, Print) westmiter MD

State Registrar

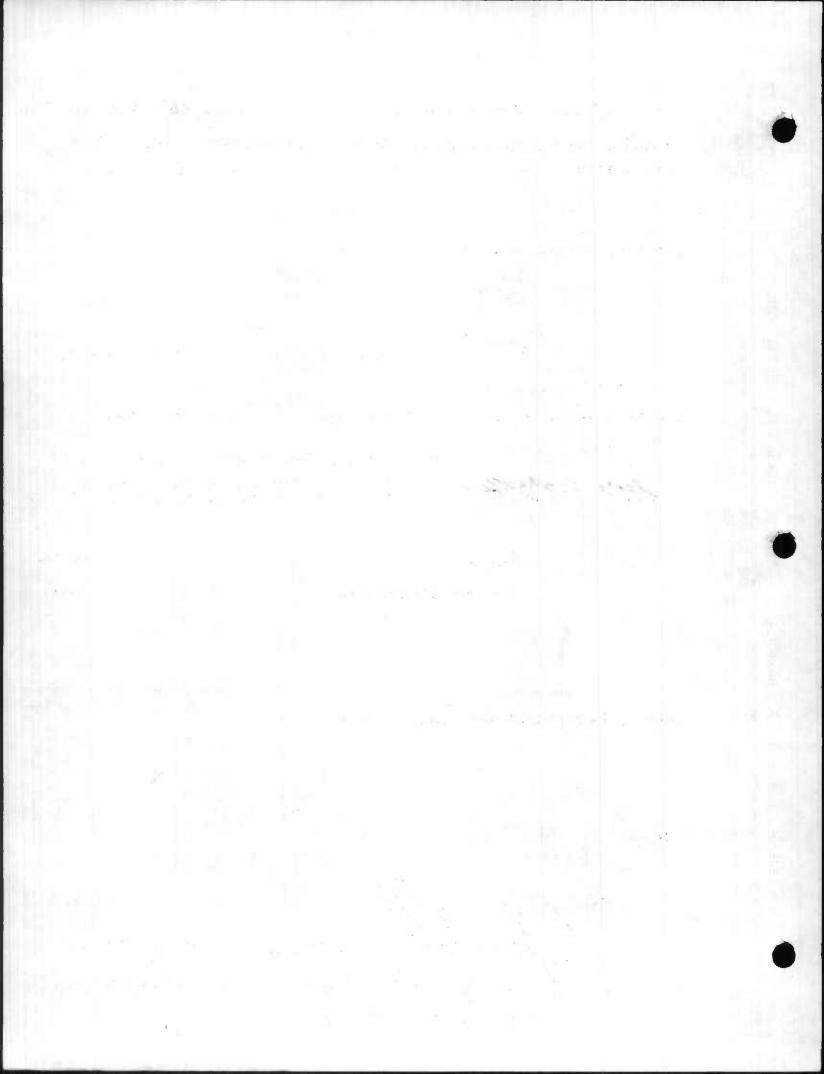
Alexander Bur

31. Date filed (Month, Day,

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32. Registrar's Algnature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death 230 Month **Physician** George Vernon Warring ton am /Medical 4e. Facility Name (If not Institution, give street end number, 4b. City, Town, or Location of Des 4c. County of Death Examiner Elizabeth Arbut If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days 216 03 9847 90 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Anne Arunde 1 ☐ Yes 2 No PASAdenA Directo event, the Medical Examiner must be notified 10e. Street and Number 10g. Citizen of What Country? 8 United 8080 States Rems 23a Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giver Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No tf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify 8 Maryland 21215-0020 Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Kemodeling Vaintes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be and Mental P WATER Edward is marked Warring Amelia Grace MAIRS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Important: if item 27 is any injury or other 1 Creek Rd. Pages 1 and 2 r 8080 PASAdenA MD.21122 MATGAVE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other Date 20c. Location - City or Town, State Buciel 2 Cremation 3 Removal from State 5 Q Other (Specify) 1328 Sulphur Springles 21. Signature of Funerel Service Licensee uneral Home 23e. Part1. Enter the disease, or complications that caused the deer shock, or heart feilure. List only one cause on each line. o not enter the mode of dying, such as cerdiac or respiratory arrest, Approximete fnterval Between **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be (25. Was cese referred to medicel examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 26d. Describe how injury occurred After 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral C completely filled 1 Recritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as atlated. 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17,1999 D-40521 May 30. Name and address of person who completed couse of death (Item 23e) (Type, Print) 3350 WILKERS Frences State 302 DR OCHANEY Baltimore, MD 21229

DHMH 16 Rev 6/95

State Registrar

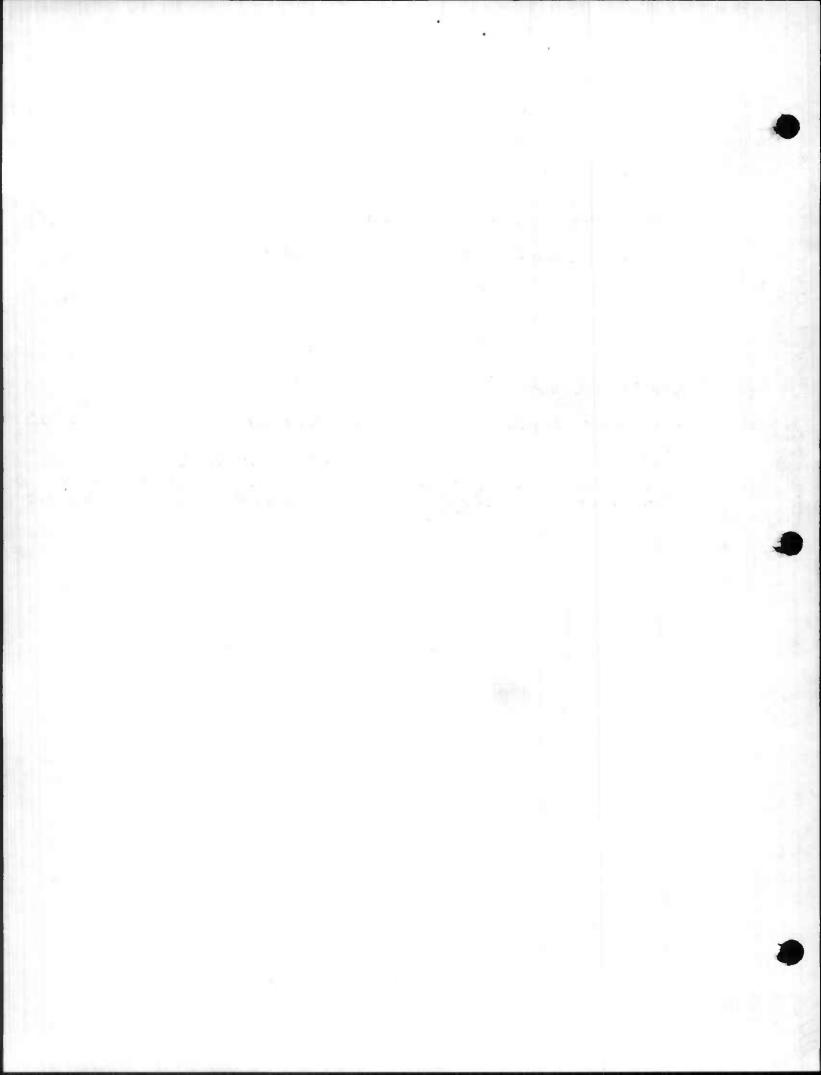
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31. Date filed (Month, Day, Yeer)

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32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

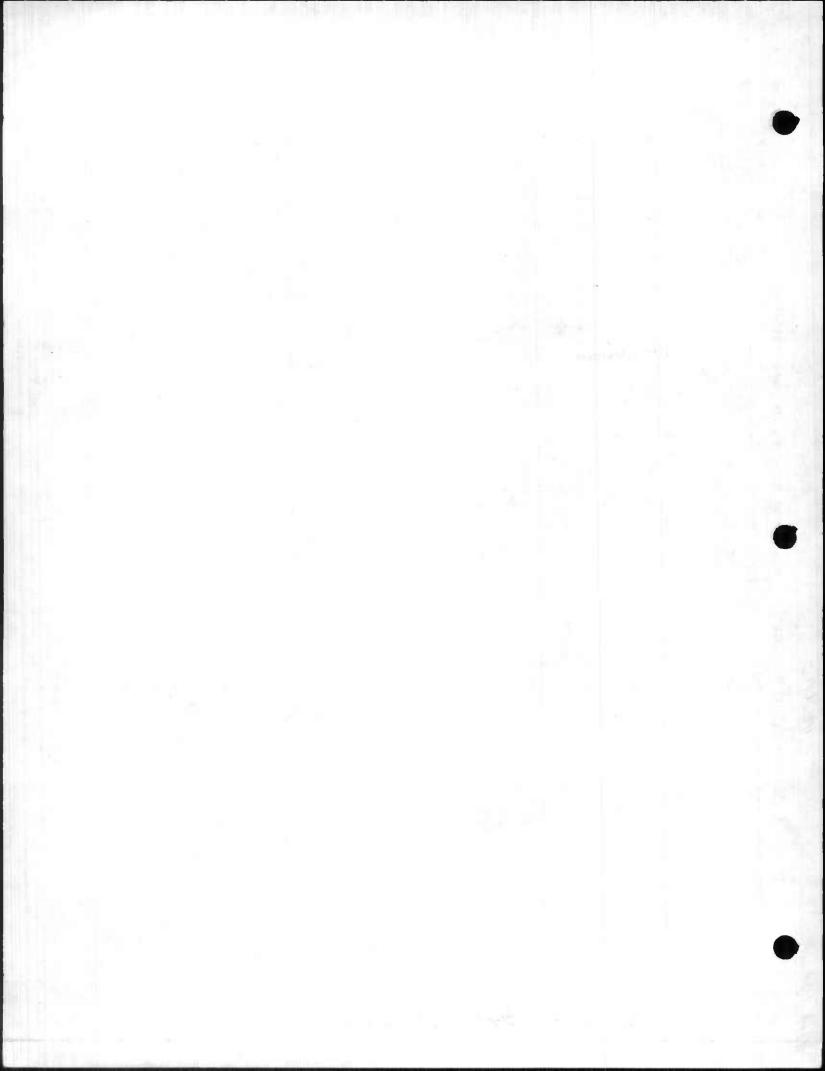
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** James Edward Wilev May 99 11, 8:15pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1530 Windemere Avenue Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 F Months 244-52-4282 Yrs. Director 60 05-03-39 NC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23s or 28s-f show 1□Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1530 Windemere Avenue 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian the Medical Examiner Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental hygiene. Important: if item 27 is marked other than nath any injury or other traumatic event, the Medical pages. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 10th Grade Bethlehem Steel Co. NA Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eddie Helen Wiley Bowens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Wilev 1530 Windemere Avenue Baltimore, Maryland Alva 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom State Baltimore Cemetery 05-18-99 Baltimore, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 world Examiner Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Box 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Prosettings Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s PH. 1 ☐ Yes 2 TNo 1 Yes 20 No of Vital 25. Was case referred to medical 8 26. Placa of Death (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Division or Attanding 5 Pending investigation s after death. Il Director: Aft ed in by the fur NA 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral Completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1740609 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
(Taurice Ruden. WD 1005 No Post Blvd-Svite 700, Barty) Janice Ryden 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 16 Rev 6/95

MAY 1 8 1999



physician and US6.53 signed t page 2 s has certificate 8 10 this

P.O.

Records,

Division of Vital

The law requires that

After Attending

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun.

Physician/Medical by Completed 25. Was case referred to medical

Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

XX Yes 2□ No

27. Manner of Death

1 Natural

2 Accidant

3 Suicida

29a. Cartifiar

4 Homicida

(Check only

Due to (or as a consequence of)

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending Investigation Injury

MAY 9, 1999 3:20 AM 1

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

STREET

28c. Injury at Work?

29c. License number

1 Yes 2 No

Other: 4 Nursing Home 5 Residence Monthar (Specify) AT SCENE 28d. Describe how injury occurred Subject was shot

1 Yes 2 No

24a. Was an autoosy

1 Yes

26. Placa of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 800 block Harlem Ave, Baltimore, MD 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the tima, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar

6 Could not be datarmined

O.C.M.E

29d. Data signed (Month, Day, Year) MAY 9, 1999

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were sutopsy findings available prior to completion of cause of death?

Yas 2 No

30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

1999

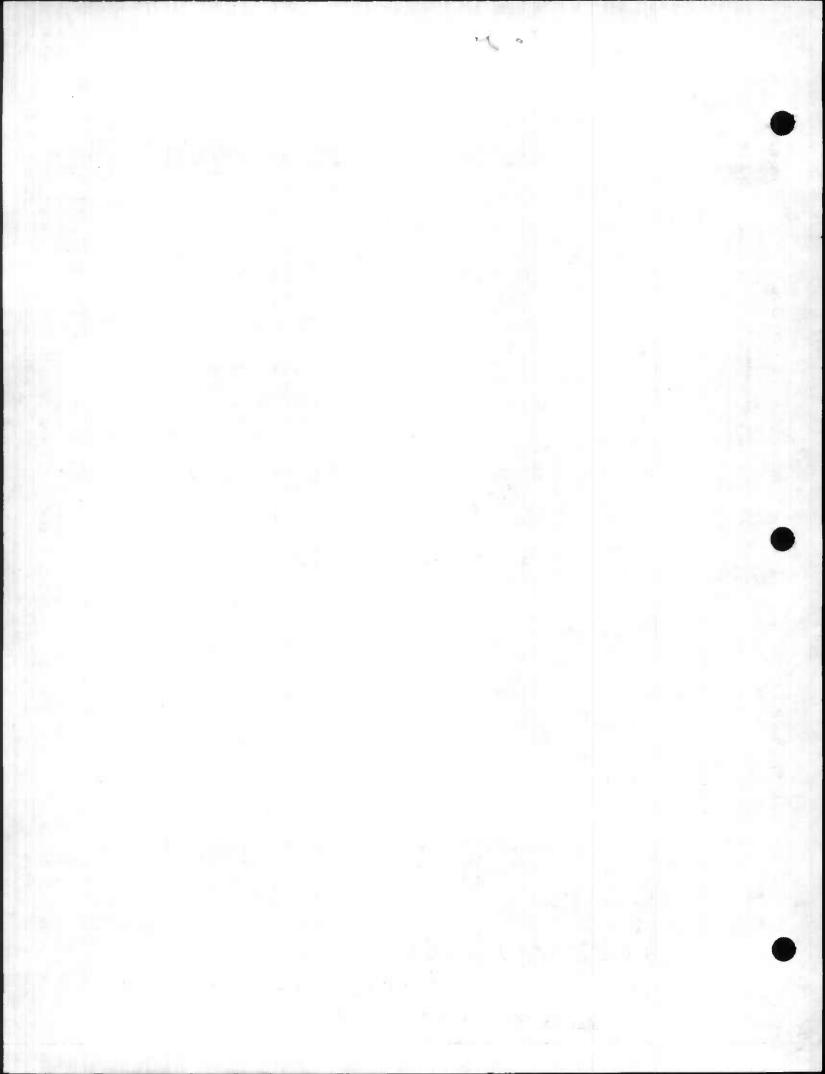
Stephen 5, Radent2 111 Penn Street, Baltimore, Maryland 21201 32. Registrat Signatura 31. Date filed (Month, Day, Year)

State

edical Certification:

ORIGINAL

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death **Physician** Washington 3:10 PM Mac -110 /Medicai 4a. Facility Neme (If not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOME 315 INGLESIDE FICKEST HAVEN NSG. CATONSVILLE BALTIMORE 8. Date of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign Country)

SC. **Funeral** 7-36-4160 1 M 2 V Director Usual Residence of Decedent 10b. County 10e. State 10c. City, Town or Location 10d. Inside City Limits Herne 23e or 28a-f show Director 1 Yes 2 No MD. BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 315 INGLESIDE AVE. 21228 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after de Il Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No Specify: þ Specify BLACK 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filled will Department of Health and Mental Hygiens Important: If Nem 27 is marked other that any Injury or other traumetic event. 12 HOMEMAKER HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) JIM WILLIAMS 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) NOVELL WASHINGTON 137 MARYDALL DR. WESTMINISTER MD. 21157 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM PARK 5-13-99 BALTIMORE MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 Enter the disease, or complications that of sed the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, k, or heart feilure. List only one ceuse on each line. Onset end Death **Physician** /Medical Immediate Ceuse (Final SEPSIS disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): attending physician for use es the buria Records, P.O. Box 68760 Physician/Medicai Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Yunkhown Be Completed by ate hes been signi page 2 should be 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Was an autopsy performed? this certificate 2 100 1 Yes 2 Ad Division of Vital Hospital or Attending Physiciam: 24 hours efter death. Funeral Director: After this certifica etely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) To 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Medical Certification: 1 Natural 5 Pending Investigation 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled In Till Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) end manner steted. 29e Certifier 29b. Signatura and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21208

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Registrar

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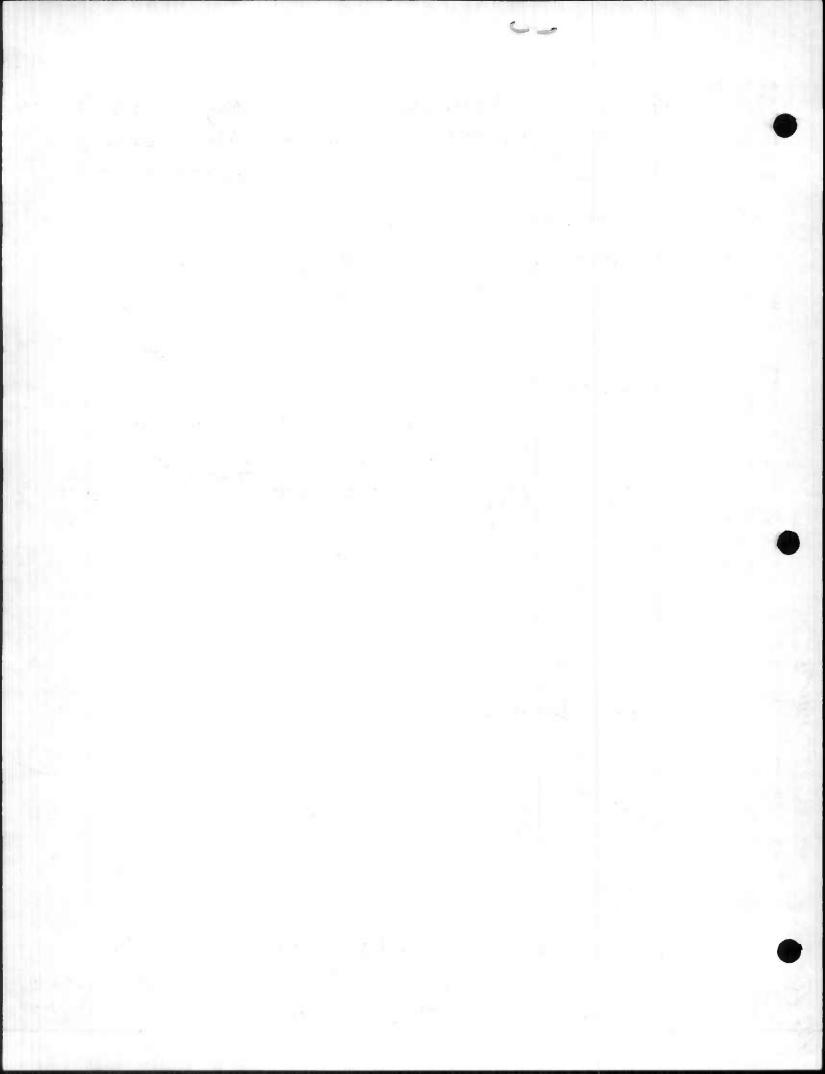
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1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** WILKINS 7:35 P.M. 1999 ROBERT 12 MAI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIHORE HOSPICE WAL JOSEPH RICHIE 5. Social Security Number 7. Age (In yrs. last birthday) 9 4 Yrs. Birthplace (State or Foreign Country) **Funerai** Days 1 M 2 □ F 217-05-6476 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at MARILLAND 1XYes 2 □ No BALTIMORE Directo 10e. Street and Numbe 10g. Cilizen of What Country? ò +H STREET USA. Items 23a 2121 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2☐ Married 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Dacedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed withIn 7 Hygiene. other then Elementery/Secondary (0-12) College (1-4or 5+) TRUCKING COMPANY TRUCK DRIVER UNKNOWN 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be to Department of Health and Mentel Important: If item 27 is marked or eny injury or other treumatic ever UNKNOWN UNKNOWN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2305 W. LEXINGTON ST. BALTIMORE, MD. 21223
ace of Disposition (Name of Data 20c. Location - City or Town, State LARRY KEATON (GRANDSON) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State KING MEMORIAL PARK 05-17-99 WOODLAWN, MARYLAND

22. Name and Address of Facility

JOSEPH, H. BROWN JR. FUNERAL HOME

ABOUNDED AVE. BALTO. MD. 21217

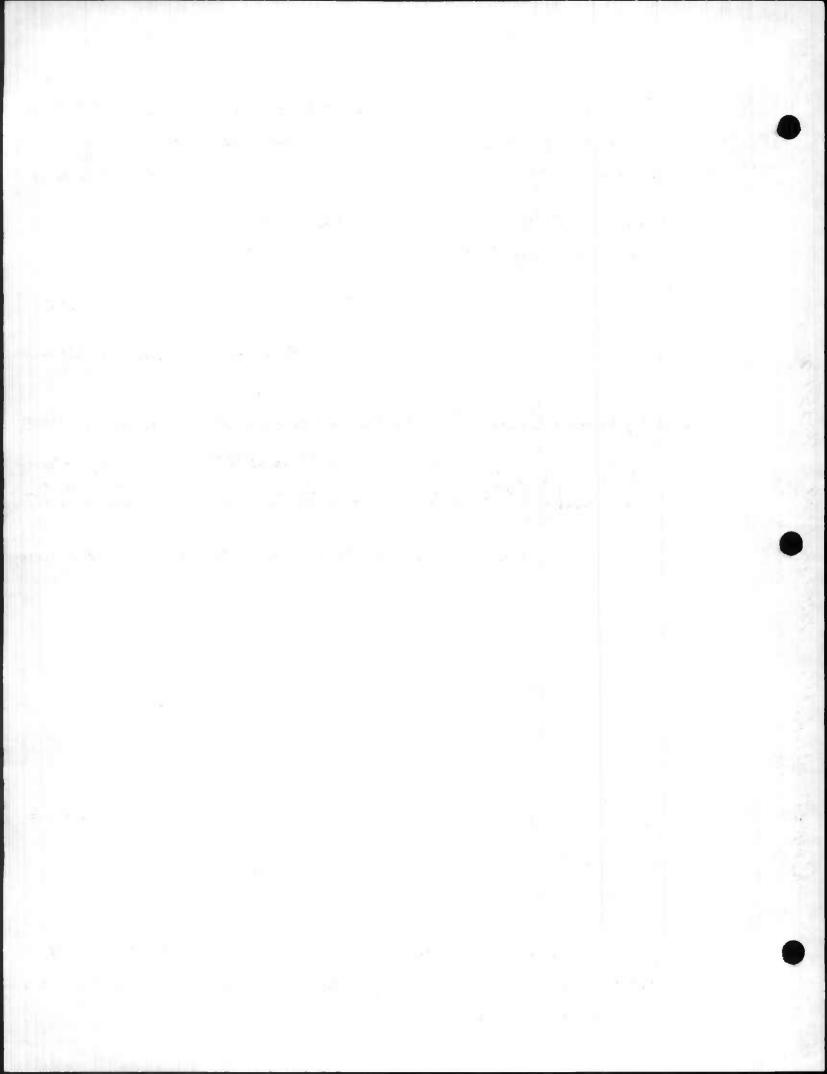
a death. Do not enter the mode of thing such as cardiag or reprised on the such as cardiag or reprised or treet. 4 Donation 5 Othar (Specify) Funeral Service Lifer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final ADENO CARCINOMA COLON WITH METASTASES disease or condition resulting in deeth) 13 HUNTE Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disaase or injury that initialed events resulting in death) Last Due to (or es e consequence of). Physician/Medicai Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Phyaicfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examinar: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print)

MAC GIBBON HD IOI WESTREAD STREET SUITE 719 BALTIMORE MAY YAND ZROI

State Registrar JOHN B. M 31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 4b City, Town, or Location of Death 4c. County of Death 4a Facility Name (If on Institution, give 8. Date of Birth Month, Day June 15 A KI If Under 1 Year 9. Birthplace (State or Foreign Country) PA 5. Social Security Number Age (In yrs. last birthday) Months Days Hours Min. Yrs. 75-20-Usual Residence of Deced 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Md. Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 North Charles Road 21201 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes Ž No Specify: White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Payroll Accounts Railroad 12th 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Nestor Engle Elizabeth Sanner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) BarryBerkenkemper / son 513RappolaSt. Baltimore Md. 21224 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc. 5/17/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licenses Connelly Funeral Home of Essex 300 MACE Ave. Baltimore Md. 21221 Part1. Enter the disease, or complications that caused the death shock, or heart failure. List part one cause on each line. Approximate Intervai Between Onset and Death ARAHTTHMIA immediete Cause (Final disease or condition resulting in death) ACUTE CARDIAG MINUTES Due to (or es e consequence of): INFANCTION ACUTE MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of): A CUTE CONONANT ANTENT OCCLUSION Due to (or as a consequenca of): ARTEALOSCLEADSIS COMPKANT 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yas 2 ☐ No CONDNANT ANTERY DILEASE 24b. Were autopsy findings available prior to 32 A36) C 24e. Wes an autopsy completion of cause of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 28. Pteca of Deeth (Check only one) Hospital: Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28c. Injury et Work?

/Medical **Examiner** that the death certificate be executed

Physician

Physician /Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

with the Maryland

death

filed within 72 hours after

Hygiena.

f Health end Mantal Hygi flem 27 is marked other other traumatic event,

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum page.

should be find Mantal I

altimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records,

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To the Hosp within 24 hou To the Fune completely fi

ettending physician and for use as the burial-trensit use as t certificate has b irector, page 2 s this

Physician/Medical Examiner þ Completed Be Certification: To death. ector: 6 Olre 24 hours e Funeral D letely filled

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I.

CHAONIC OBSTAULTIVE PULMONARY

28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation Natural 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

📆 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 00

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

301 ST. PAUL PLACE BALTIMOTE MS 21202 JOSEPH D. MOTARANGELP M.D.

State Registrar

edical

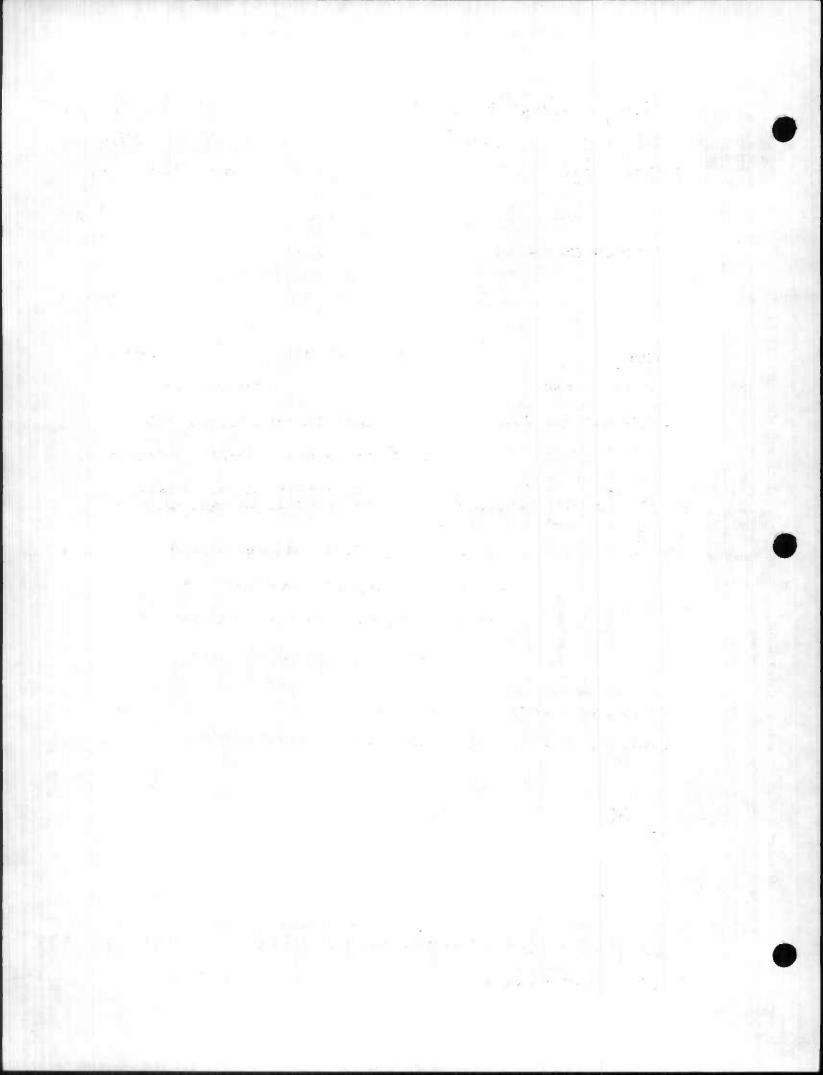
31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

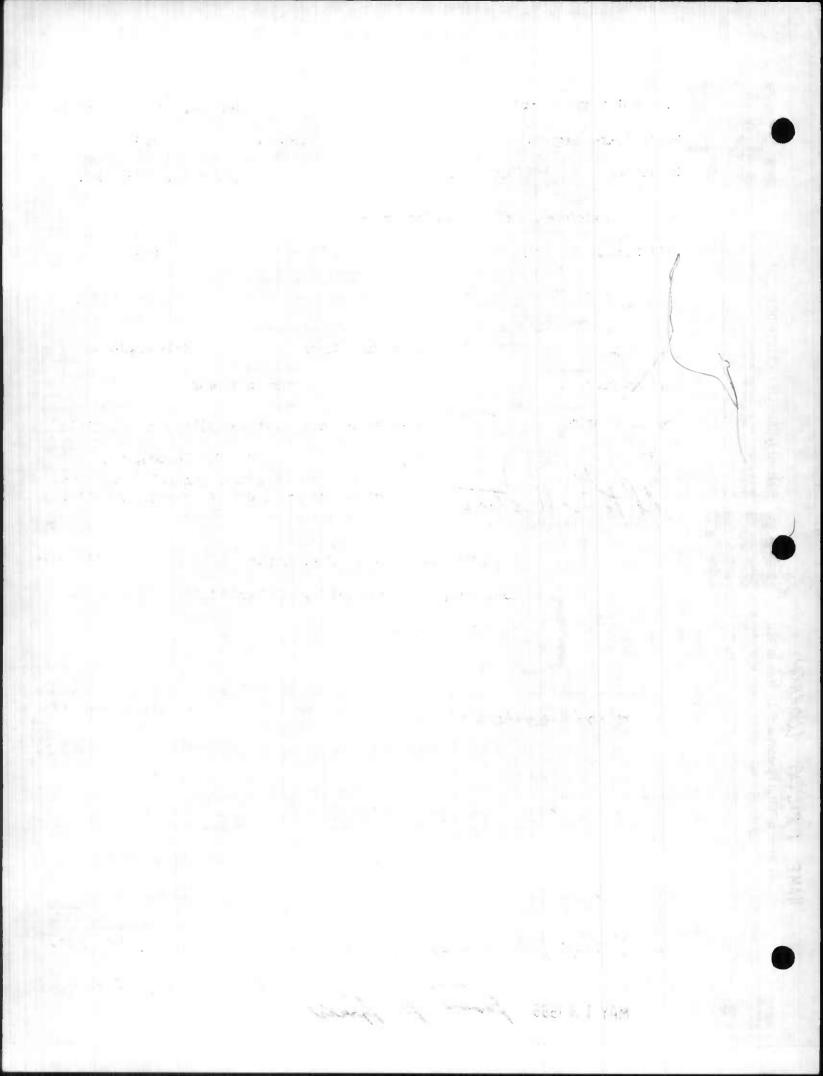
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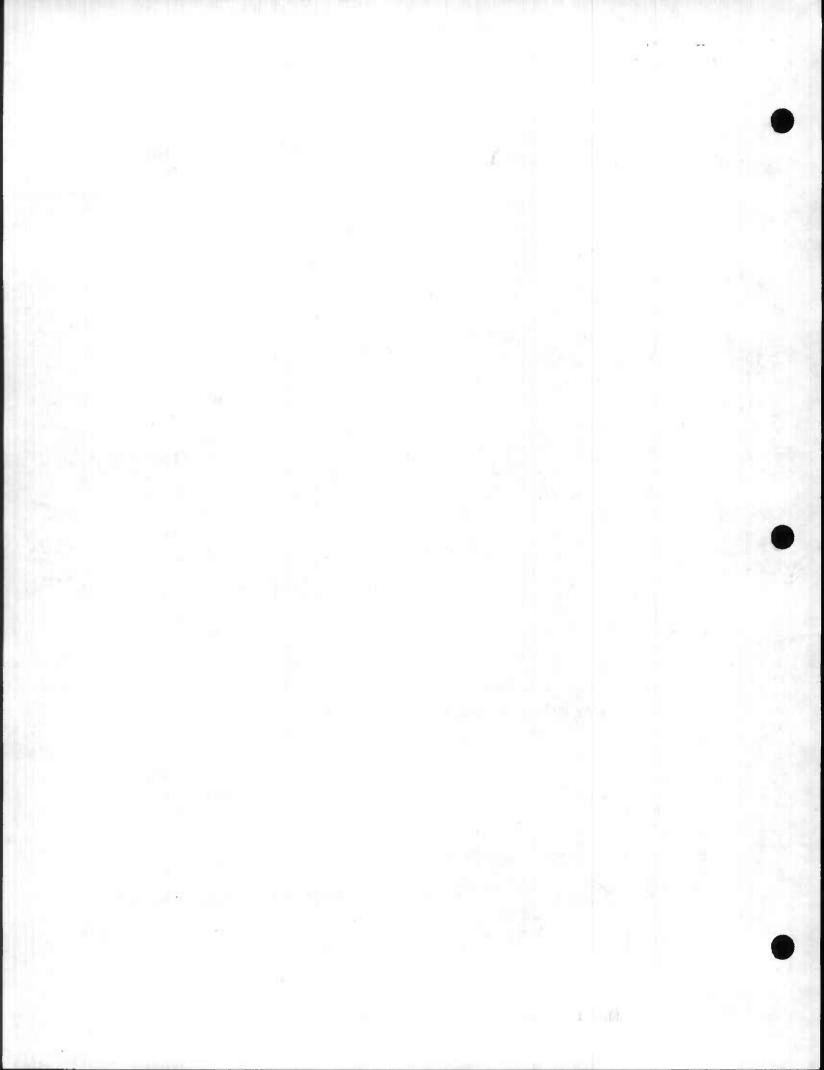
Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				arylari		ertificate		Death		Reg. No.	99	159	143
Physician /Medical		me (First, Middie, Las Johnson Wa							2. Date of Do Month MAY 1	Day	99 Yaer		a of Death
Examiner		(If not institution, give)				4b. City, Town, or L Baltimore			county of De	eth	
Funeral Director	5. Sociel Security 215–14–8	3873 ¹	ax 7. Aq	ge (In yrs.	lest birthdey Yrs.) if Undar 1 Months			8. Dete of Bi (Month, Di April	rth e <i>y, Year)</i>	9. B	rthpiece (Sta Country)	ata or Foraign
/and	Usuel Residence 10a. Stete	of Dacedeni 10b. County		10c. City	y, Town or L	ocation			-			10d. insid	le City Limits
vith the Men tor 28=1 sh be notified	Md.	Baltimor	е	Rar	ndalls								Yes 2 No
uth with the Meryla 23a or 28a-1 show with the motified at		ownbrook C	ourt			10f. Zip (2	21133			en of What C	Country?	
b, Maryland 21215-0020 end 2 should be filed within 72 hours after death with the Meryland selth end Mental Hygiene. n 27 is marked other than "natural", or items 23s or 28s-1 show her treumstic avent, the Medical Exerting must be notified at To Be Completed by Funeral Director	3 ☐ Widowed	rried 2 Married 4 Divorced	12. Was Decedent Armed Forces' 1 Tyes 2 If If Yes, Give Year or Detes:	?	.S. 13.	Wes Decede If Yes, speci		Hispenic Origin? (Spen, Mexican, Puerto Specify:	pecity Yes or No Rican, etc.)		4. Race - Arr Bleck, Wh Specify:		1,
21215-0020 ed within 72 hours at yolene tra Madical Exam. c. tra Madical Exam. Completed by F	(Spa	15. Decedent's Ed acify only highast gra- condary (0-12)	lucation de completed) College (1-4or	5+)		a kind of work DO NOT use		pation during most of work od)	king		d of Busines -Emplo		
d 212 filled withi Hygiene. Hygiene. Hygiene. Hygiene.		ade (First, Middle, Last)			TOTIC	care	IVUI	18. Mother's Nem	ne (First, Middle		-	yeu	
yland yland build be fil Mental H arked oth attc aver	Clifton	Johnson						Gertrude	e Thoma	S			
Mary d 2 sho h end I 7 is me treume		Neme/Reletionship (7	Type, Print) hus	band				t end Number or Ru					
	20e. Method of Di		Removal yom State		Place of Disp emetery, cre	osition (Nemerotory or other Valley	e of her pla		Dete May 21	20c. Loc	on, Mo	r Town, Stet	
Baltimore permit. Pages 1 Department of H Important: if its any injury or or		ungfal dervice Licen	,	1					utter F				
Physician /Medical Examiner	Immediete Ceuse disease or condit resulting in deeth	ion	e. Myo	avo	1	7 u T	Pa	rcTion	or respiretory			Approxintervel Onset e	Mete Between and Deeth
I Records, P.O. Box 68760, The law requires that the deeth certificate be executed the been signed by the ettending physician end page 2 should be deteched for use as the bunal-transit completed by Physician/Medical Examiner.	Ceuse (Diseese of that initiated even rasulting in daath	conditions, Immadiate Jerlying or injury its) Lasi	c. dic	6 e	r es e conse	equence ol):		7					
Januer P.O. Box (hat the deeth certified deeth derise deteched for use Physician M.)	Pert II. Other sign	ificant conditiona co	ontributing to death t	out not res	ulting In the	underlying ca	iuse gi	ven in Pert I.					use of death?
ds, P. iries that the signed by d be detected by Phy		ruol f	Poilur	C					1	Yes 2[□ No 3□	Probably	4 🗷 Unknow
I Records, The law requires to the law requires to the law requires to the law requires to the law requires to the law requires to the law requirement						4.			24a. We	s en eutop ormed?	sy 24t	evelleble p completion of death?	rior to
									1□	Yes 2	1No	1 🗆 Yes	2 No
of Vital F of Vital F Physician: The ribis certificate frail director, page	25. Was case refe examiner?	erred to medical	Hospital: 1 ☐ Inpati	ieni 2	FR/Outpetle	ent 3 DO	A Ot	26. Plece of Dec	oth <i>(Check only</i> ome 5 Res		☐Other (St	necify)	
n o n o o o o o o o o o o o o o o o o o			28e. Dete of Inju		28b. Time Injury	ol 28	Bc. Inju		28d. Dascribe				
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral Medical Certification:	3 Suicide 4 Homicide	6 ☐ Could not be determined	28e. Plece of Inbuilding, a	iury - Al ho tc. (Specif	ome, ferm, s	streel, fectory,	, offica		28l. Location City or To	(Street and own, Stete)	Number or	Rural Route	Number,
NAN To the Hospital - Within 24 hours a To the Funeral E completely filled Medical Ce	29a. Certifier (Check only		ysician: To the best hinar: On the basis of end menner s	of examine									ise(s)
To the within 2 To the comple	29b. Signature an	of title of certifier	- end menner s	aled.		1,000,00	210237	se number		29d. Date	signed (Mo	nth, Day, Ye	nr)
		AA	11/2			1	12	1256		Me	y 1	1, 19	78
6	30. Neme end edd	dress of person who d		Aa	1 23e) (Type	Print)	Ni-	ral, 6	Paltin	100	· M	anale	and .
State Registrar	31. Dete liled (Mo	IAY 1 8 199	32 Regist	rer's Signe	-	doa	K				7		



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Amended Iter	n 8, per FH,G771,5/24/	State of Ma 99dhb	•	epartment Certificate					giene g	9	15944
	1. Decedent's Neme (First, Middle, L	ast)						2. Date of Dea	ith		3. Time of Death
Physician	Charles William	Williams						Month	13 ^{ey} 19	999	5:12pm
/Medical Examiner	4a Facility Name (If not institution, gi		,		1	4b. City, To	wn, or Lo	ocation of Death		of Death	
LAMITIME	Hamilton Center					Balti	more		N/A		
Funeral	Sociel Security Number 6.	Sex 7. Ag	e (In yrs. last birt	hday) If Under	1 Year	If Under	24 Hrs.		1	9. Birth	place (Stete or Foreign
Director	219-14-8368	11 M 2□ F	73	rs. Months	Deys	Hours	Min.	June 15	1925	Mar	vland
D.	Usual Residence of Decedent										
arylar ahow	10a. Stete 10b. County		10c. City, Towr								10d. Inside City Limits 1
the Marylar 28a-f show nother a	Maryland N/A		Ba	ltimore							
vith the Ma t or 28=1 s be notified	10a. Street and Number			10f. Zip					10g. Citizen of V	Vhat Cou	ntry?
1020 July after death with the Maryla air, or items 23a or 28a-1 sho Examinat must be notified at by Funeral Director	3201 Glenmore Av				2121				United		
Here dea	11. Marital Stetus	12. Wes Decedent Armed Forces?		13. Wes Deced	ent of H ify Cuba	lispanic Ori an, Mexican	gin? (Sp , Puerto	ecify Yes or No- Rican, etc.)	14. Hac Blac	e - Americ k, White,	etc.
o20 urs afte	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ I If Yes, Give	WWII	1 ☐ Yes 2	Z No	Specify:			Specify	Wh	ite
11215-0020 within 72 hours after death with the Maryland and than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at smpleted by Funeral Director	15. Decedent's E	Year or Detes:		Decedent's Usue	1 Occur	ention	_		16b. Kind of Bu	iclnoce/lo	dusto
1 21215-0 led within 72 ho vygiene. In the Medical Completed	(Specify only highest gi	rede completed)		(Give kind of wor	k done	during most	t of work	ing	TOD. KING OF BU	23111033/111	ousily
d 212 filed with Hygiene. they then and, they	Elementery/Secondery (0-12)	College (1-4or 5	i+)	Dump Tru			r		Potts	and (Callahan
be filed tai Hygin avant, the Be Co	17. Fether's Neme (First, Middle, Las	t)						e (First, Middle,			ou i i u i u i
yian ouid be Mentai Mentai arked o atic ave	Conrad Williams					Alm	a M	lercer			
Maryjand 212: d2 should be filed within th and Mental Hygiene. 7 is marked other than traumetic avant, the M To Be Comp	19e. tnforment's Neme/Relationship		19b.	Meiling Address	(Street				r, City or Town,	State, Zip	Code)
■ 5 = 7 ± 5	Gertrude T. Willi	ams / Wif	e 3	201 Gler	nmor	e Ave	nue	Balto.	, MD 21	214	
or Health	20a. Method of Disposition		20b. Place of	Disposition (Nem	ne of			Dete	20c. Location -	City or To	own, Stete
Pages nent of mr: If lity iry or o	1 ☑ Burial 2 ☐ Cremation 3 I 4 ☐ Donetion 5 ☐ Other (Spec			alley Mem		100	ns 15	/15/99	Timoniu	m. Ma	arvland
Baltimore, permit. Pages 1 at Department of Hear Important: If Itam; any Injury or othe page.	21. Signeture of Funerel Service Lice	ensee Timoth									
W SEES		Harman		5305 Ha	rfo	rd Ro	ad,	onard J Baltimo	re, Mary	ytand	21214
	23a. Part1. Enter the disease, or cor	nolications that caused	the death. Do n	ot enter the mode	e of dyin	ng, such as	cardiec	or respiretory er	rest,		Approximate
Physician	shock, or heart feilure. List only	y one ceuse on each lii	10.							i	Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition	D	neum	15,00						1	1 monte
Examiner	resulting In deeth)	8.		onsequence of):							2 years
je z		. (bron:	c Ren	al	Fa	ilui	ne			2 years
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner	Sequentially list conditions,	D	Due to (or as a c					-		1	
1760, start be expression a burial-	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	0									
is, P.O. Box 68760, as that the death certificate be executioned by the attending physician and be detached for use as the burial-trail by Physician/Medical Exar	that initiated events resulting in death) Last	0.	Due to (or es e c	onsequence of):							
P.O. Box 68 at the death certifica by the attending ph etached for use as th		l d									
Box sath cert for use										İ	
O o o o o o o o o o o o o o o o o o o o	Pert II. Other significant conditions							23b. Did 1	obacco use co	ntribute t	o the cause of death?
P.O. hat the detached by the detached	(ereb	ro Vascu	lay f	ccide	201 t	-		10	rea 28 No	3 Pro	bably 4 Unknown
Records, P ne law requires that e has been signed to age 2 should be det completed by P								Ode Wee		24h W	ere autopsy findings
In Record The law require tate has been single 2 should Completed								perfo	an autopsy med?	84	vallable prior to empletion of cause
Red e law										of	death?
								101	es 2 PNo	11	☐ Yes 2☐ No
vision of Vital Re Attanding Physician: The is octor: After this certificate he by the funeral director, page iffication: To Be Com	25. Wes case referred to medical axaminer?	Hospitel:			Oth	or .		h (Check only o			
0 5 5 8	1 Yes 2 No 27. Menner of Death	1 Inpatie			A	4 E NU	irsing Ho	ome 5 Resid	lence 6 Oth		fy)
Affect fune	1 ☑Netural 5 ☐ Pending	(Month, Day		njury M	8c. Injur Wor	rk? Yes 2□	No	200. 500011001			
Division of tal or Attanding P is after death. Sel Director: After led in by the funers Certification:	3 Suicide 6 Could not	be One Diseased Indi	urv - At home, fa	m, street, fectory		101		28f. Location (S	Street and Numb	er or Run	al Route Number,
Diversion of the district of t	4 Homicide	building, etc		,	,			City or Tou	m, State)		
	29e. Certifier 1 € Certifying P	hysician: To the best of	of my knowledge	deeth occurred a	at the tir	ma, date an	d place.	and due to the	ause(s) and me	enner as s	stated.
n 24 hou n 24 hou ne Fune pletely fil	(Check only 2 Medical Exa	miner: On the basis of end manner ste	examinetion end	Vor Investigation,	in my o	pinion, dee	th occur	red et the time,	date end place,	and due t	o the cause(s)
N withir	29b. Signature end tille of certifier	1 LL	. 0/	29c	Licens	se number			29d. Date signe	d (Month,	Day, Year)
	Dala.	ATTEND!	at hude	sieval.	1	200	536	4-2	May 1	41	999.
0	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)			570			,	
1	X/AUMIND	ZHOUME	300	7 F. L	1915	ther	n f	arkwa	4. Bal	timo	999. re MD.
State	31. Dete filed (Month, Day, Year)	32. Registro	er's Signeture	1	,		-				
Registrar	MAY 18	1999	wa	B. Se	rous	6					

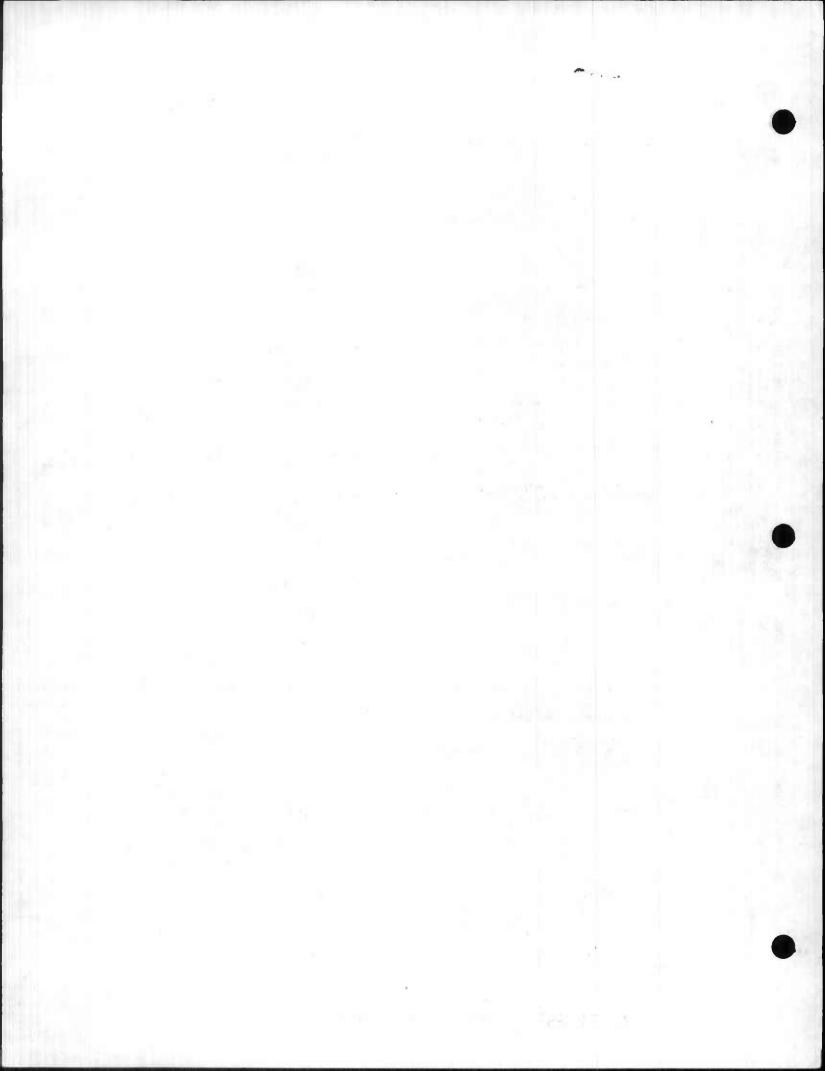


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State of Maryland / Department of Health and Mental Hygiene

	_	1. Decedent'a Nama (First, Mid	die, Last)		Certificate of	Death	2. Date of Death	J. No.	3. Time of Death
	Physician /Medical	Helma Marie	Wafer				May 13,	1999 Year	5:45 PM
	Examiner	4a Facility Name (If not instituti	ion, give street and number)		4b. City, Town, or L	- Y	4c. County of De	ath
		Genesis Elder				Baynesvi			imore
	Funeral Director	5. Social Security Number 217-26-0708 Usual Residence of Decedent	6. Sex 1 ☐ M 25XF	ge (In yrs. last bir	thday) If Under 1 Year Months Days		8. Data of Birth (Month, Day, 1) Feb. 19,		inthplaca (State or Foreign Country) rmany
	Page 18	10a. State 10b. Count	ty	10c. City, Town	or Location				10d. Inside City Limits
	the Mary start sh notified.	Maryland N/A		Balti	more				1 Yas 2 □ No
15	or 28er a be notified	10e. Street and Number			10f. Zip Code		109	g. Citizen of What C	Country?
	rel rel	3502 Glenmore	Avenue		2120	6	l	United St	ates
21215-0020	urst, or hems al Examiner or d by Fune	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorce	If Yas Giva	? No	13. Was Decedent of If Yas, specify Cub		ecify Yes or No- Rican, atc.)	14. Race - Am Black, Wh Specify: W	
2	ad within 72 ho yglens. we than "naturi it, the Medical. Completed	15. Decede (Specify only high	ent'a Education lest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ing 16	6b. Kind of Busines	s/Industry
121	H Paris	Elementary/Secondary (0-12)	College (1-4or	5+)		od)		Own Home	
9		17. Father's Nama (First, Middle	e, Last)		Homemaker	18. Mother's Nam	a (First, Middle, Ma		
Maryland	Mental Parket of street of street of street of To Be	Andrew Hoesl					Hacker		
Bry	nd M	19a. Informant's Name/Relation	nship (Type, Print)	19b.	Mailing Address (Stree			City or Town, State,	Zip Code)
2	and 2	Ms. Janice Sa	chs / Granda	ughter	3502 Glenm	ore Avenu	e Baltimo	ore, MD 2	1206
Baltimore	Pages 1 sent of He rut if Nem ry or oth	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (cemeter	Disposition (Name of y, crematory or other plane ne Park Ceme			oc. Location - City o	
Balti	Departit Departit Importa any inju	21. Signature of Funeral Service	Licensee Timothy		22, Name and Address Leonard J. 5305 Harfo	ass of Facility Ruck, Inc.	Funeral	Home	
		23a, Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause	d the death. Do r					Approximata
þ	Physician /Medical	Immediate Cause (Final disease or condition	st only one cause on each	ac v	, -				Interval Batween Onset and Death
	Examiner	resulting in death)	0.	Due to (or as a c	consequence of):	PHEUM	W 11/15		& Zweeks
	n end tel-transk		- Sev	ereve	7/2/10 m	eus der	ented		5 event-
	physician and physician and a the buriel-transit and Cal Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	0.	Due to (or as a c	consequence of):				1
.60	Dough Burden	cause. Enter Underlying Cause (Disease or injury that initiated events	с						
-	5 00	resulting in death) Last	d	Due to (or as e c	onsequence of):				
ă	e stending of for use sician/M						1		
P.0	that the deeth certified by the attending deteched for use y Physician/M	Part II. Other significant condit	contributing to death to	e Usu	the underlying causa gi	iven in Part I.			Probably 1 triknown
Vital Records,	The lew requires that the deeth certain has been signed by the attending page 2 should be deteched for use Completed by Physician/N	- drot	beter in	elle	tur 0	7	24a. Wes an performe		. Were autopsy findings available prior to completion of cause of death?
E I	s certificate has director, page 2 To Be Comp						1 ☐ Yas	2000	1 Yes 2 No
/ita	Be Clor.	25. Was case referred to medic examiner?				26. Place of Deat	h (Check only one,		
of		1 ☐ Yes 2 De No	Hospital: 1 ☐ Inpati	-	tpatient 3LI DOA		ma 5 Rasiden	ce 6 □Other (Sp	ecity)
Division	after deeth. Director: After thi I in by the funeral	E C PROGRAM	tigation		ime of 28c. Injury Wo	ny at ork?] Yas 2 ☐ No	28d. Describe how	v injury occurred	
ō.	1000	3 Suicide 6 Could detar	mined 259. Place of In	jury - At homa, fai ic. <i>(Specify)</i>	rm, street, factory, office		28f. Location (Stre City or Town,	et and Number or i State)	Rural Route Number,
	Funar Funar float	(Check only 2 Medics one)	ing Physician: To the best il Examiner: On the basis of and manner st	of examination and	death occurred at the ti	ima, data and place, opinion, deeth occur	red at the time, det	e end place, and de	ue to the cause(s)
	Within 2 To the	29b. Signature and titla of certific	or Ol A	0 11	29c. Licen	se number	290	d. Data signed (Mor	nth, Day, Year)
		Jeff	er Oco	of or	41/09	3465	0	5-14	-99
	6	30. Name and address of physics Seff-ey	A AN CO	01, G	Type, Print) e Nesis	Elder	CAr	e	
	State Registrar	31. Date filed (Month, Day, Year		rar's Signatura	1 Spark				

ORIGINAL



Examiner

Box 68760

Division of Vital Records, P.O.

or Attending

the Hospital

physician and the buriei-transit page 2 within 24 hours after death. To the Funeral Director: A

23a. Pert1. Enter the disease, or c shock, or heart feiture. List of	complications that caused the dec only one cause on each line.	ath. Do not enter the mode	of dying, such as cardie	ac or respiratory arrest,	Approximeta Intervel Between Onset and Deeth
Immediata Cause (Finel disease or condition resulting in deeth)	eSEIZURE	DISORDER	-	1 117	1
resulting in deedily	Due to	(or as e consequence of):			
	b				
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Dua to	(or as a consequence of):			
Ceuse (Disease or injury that initiated events	c				
rasulting in deeth) Last	Due to	or es a consequence of):			
	0.				
Part II. Other aignificant condition	s contributing to death but not re	sulting in the underlying ca	luse given in Pert I.	1 ☐ Yes 2 ☐ No	antribute to the cause of death
				24a. Wes an autopsy performed?	24b. Were eutopsy tindings available prior to completion of cause of deeth?
25. Was case reterred to medical			26 Place of D	eeth (Check only one)	
examiner? 1 Yes 2 No	Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3☐ DO	Other	Home 5 Residence 6 □Ott	her (Specify)
27. Manner of Death 1 \(\sum \) Netural 5 \(\sum \) Pending 2 \(\sum \) Accident investige	28e. Dete of Injury (Month, Dey Year) etion	28b. Time of Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 Suicide 6 Could no determine	ot be ned 28e. Plece of Injury - At building, etc. (Spec	home, farm, street, factory,	, office	28f. Location (Street and Num. City or Town, Stete)	ber or Rural Route Number,

1 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

State Registrar

29a. Certifie

(Check only one)

29b. Signature ittle of certifier

30. Name and address of person

M. T

edicai

Σ

31. Dete filed (Month, Dey, Year) MAY I 32. Registra's Signeture.

who completed cause of death (Item 23a) (Type, Print)

huten

hyte, wo.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

May 12, 1999

3. Time of Death

Birthplace (State or Foreign Country)
 MD

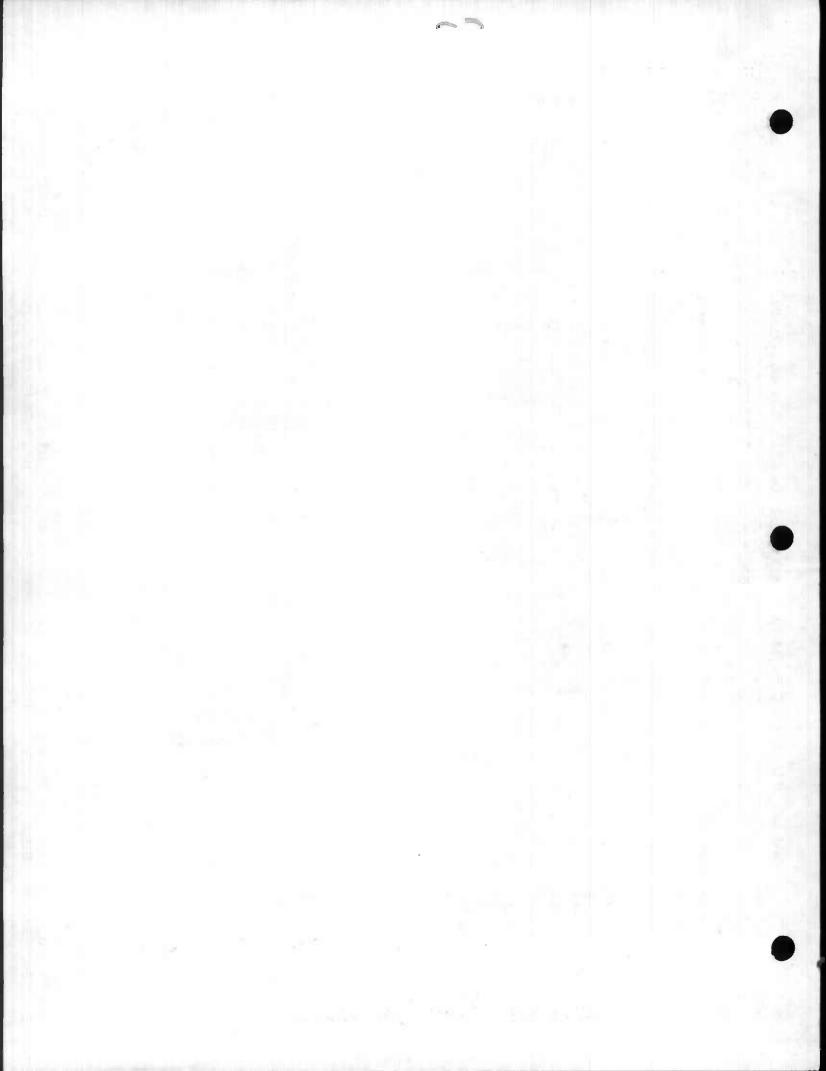
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10d. Inside City Limits

1 ☐ Yes 2 No

10:20 A.M

Year



ZITTEL , FLORENCE Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth MAY 1. Decedent's Name (First, Middle, Last) Month Physician :00 PM Florence Mary Zittel 05 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Stella Maris @ Mercy Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 1 □ M 2 X F Months 90 Yrs 215-74-5522 June 21, 1908 **Director** Maryland Usual Residence of Decedent with the Meryland 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Baltimore Directo Maryland Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21237 U. S. A. Funeral 1400 Rosewick Avenue death 12. Wes Decedent Ever In U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: by White 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) 6th Grade Homemaker Own Home pernit. Pages 1 and 2 should be filed Department of Heelth and Mantal Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event. It 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Ernest Ford Anna Ford 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Norma G. Scott (Daughter) 1400 Rosewick Avenue, Rosedale, Maryland 21237 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Method of Disposition Dete cemetery, cremetory or other plece) 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 5/19/99 Baltimore, Maryland Parkwood 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signeture of Funeral Service Licensee Buin Cl. Willem 3331 Brehms Lane, Baltimore, Maryland 21213 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel MC-Q diseese or condition resulting in death) Examiner (or es e consequence of) Examiner physicien end the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): 88 use 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be datached Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 DUnknown by 24b. Were eutopsy findings avellable prior to completion of cause of death? 24e. Wes en eutopsy Completed paga 2 1 Yes 20 No 1 Yes 2 No certificete Mans at More or Attanding Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Stulia Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 1 Yes 20 No 1 Department 2 ER/Outpatient 3 DOA Certification: To this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After Injury 1 Meturei 5 Pending after death. 1 Yes 2 No investigation 2 Accident n 24 hours after dea ne Funeral Director oletaly filled in by th 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29e. Certitier (Check only one) 1 Tertifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. Medical completaly To the Within 2 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifi 29c. License number ome end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5. Carble 308 Cm

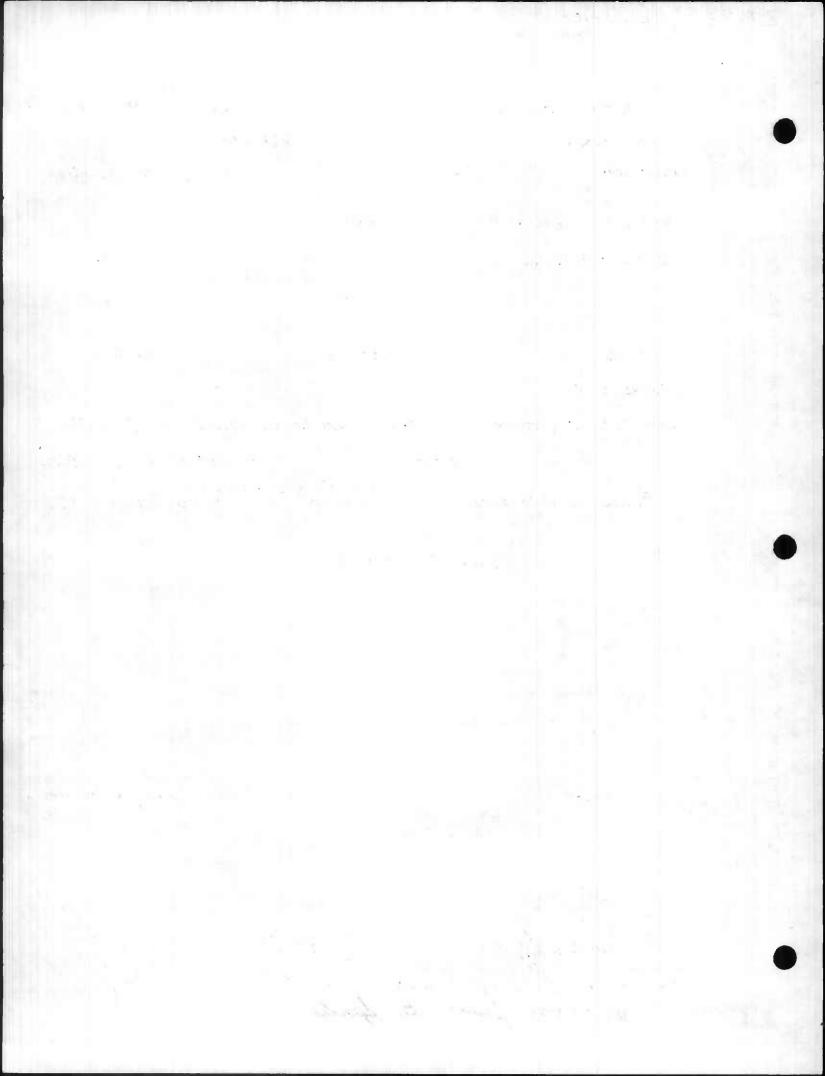
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Registrar

31. Dete filed (Month, Dey, Year)

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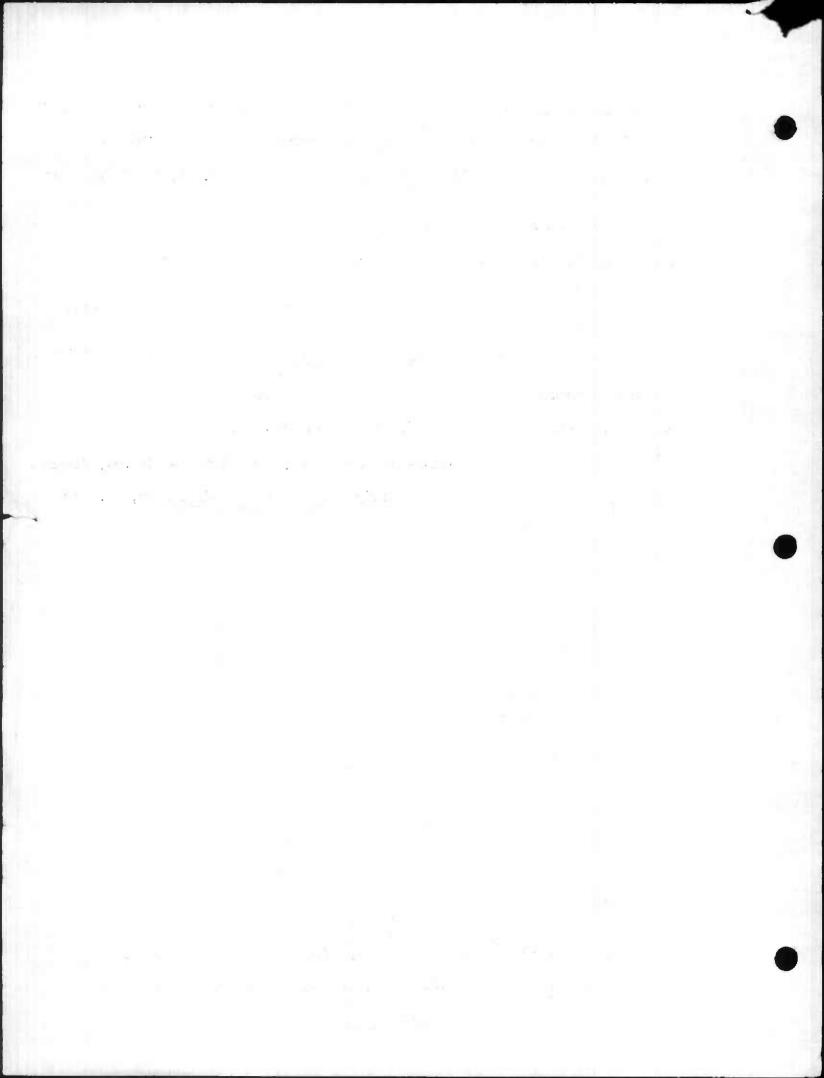
32. Degistrer's Signeture



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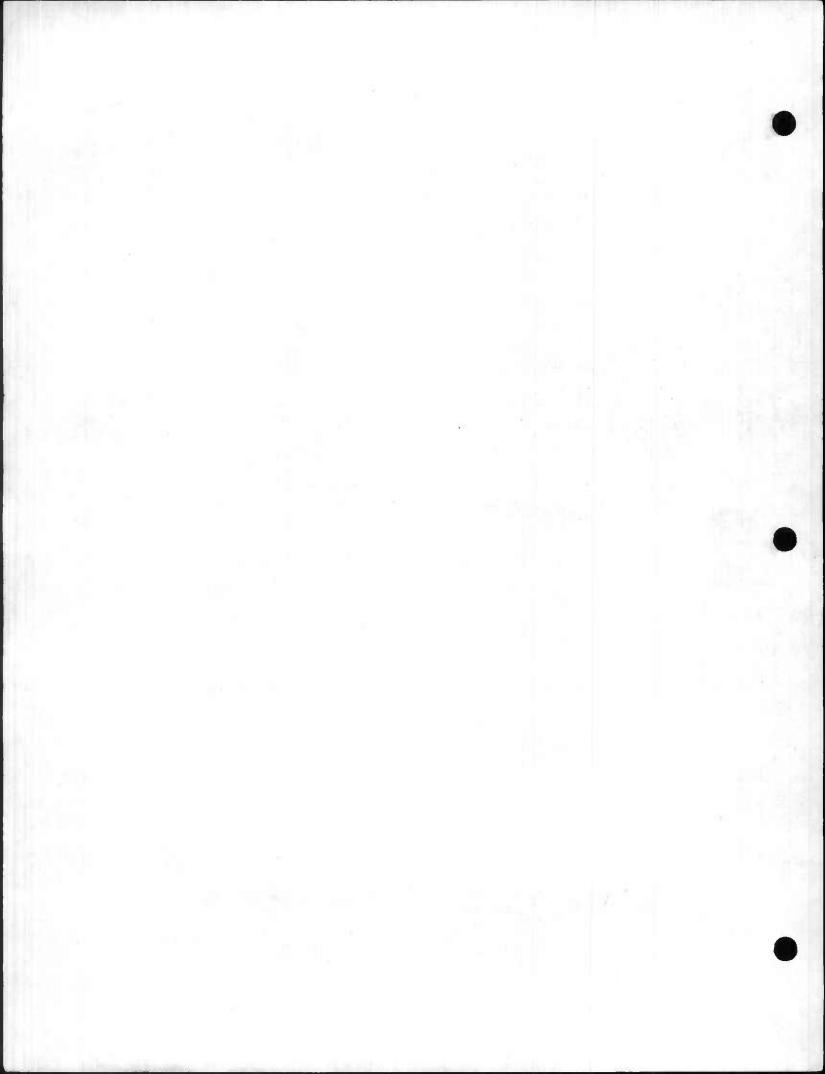
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/Medie Examir		4a. Facility Nama (If not institution, give NATIONAL INSTITU					4b. City, Town, or BETHESDA	Λ.	MONTE	OMEDV	
Funeral Director		5. Social Security Number 6. S		a (In yrs. last bi 71	rthday) If Und Yrs. Month	dar 1 Yaar is Days		8. Data of Bir (Month, Da	MONTO 12,1927	9. Birthplaca Country) Philip	(State or Foreign
D		426–49–0099 Usuai Rasidance of Decedant						bept.	12,1021	111111	princs
anylan show	-	10a. Stata 10b. County		10c. City, Tow							nsida City Limits
the M	Director	Virginia Arlingto	on	None		Zip Coda			10g. Citizan of V		LI 149 ZLAY10
3a or		1616 South Staffe	ord Street	t		22204	.1		USA	vivat Obunity i	
s 1 and 2 should be filed within 72 hours after death with the Maryland I heelth and Mental Hygiene. tem 27 is marked other than "natural", or frems 23e or 28e-f show other traumatic event, the Medical Expensive must be notified at	by Funeral	11. Marital Status 1 □ Nevar Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forces? 1 ☐ Yas 2 ☑ I If Yas, Giva Yaar or Datas:	Evar in U.S.	13. Was De		Hispanic Origin? (S an, Maxican, Pua	Specify Yas or No to Rican, atc.)		e - Amarican Ir ck, Whita, atc.	
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should be ind Mental marked o umatic eve	To Be	Fernando Agusti	1				Unavai	lable			
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ortam injur		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		COLUI			ass of Facility	5/4/1999	ALITH	gton, v	irginia
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and -trans	Examiner	Sequentially list conditions,	b	Dua to (or as a	1	of):					
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as been signed by the ett s 2 should be detached for	Physician/M	Part II. Other significant conditions co	ntributing to death b	ut not rasulting i	in tha underlyin	g causa gi	ven in Part i.	23b. Dld	tobacco use co	ntribute to the	cause of death?
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Hospital 24 hours Funeral letely filled	edical	29a. Cartiflar (Check only one) Certifying Phy Medical Exam	relcian: To the best of Iner: On the basis of and manner sta	axamination ar	a, daath occurre nd/or invastigati	ed at tha ti	ma, data and plac opinion, daath occ	a, and dua to tha urred at tha tima,	causa(s) and ma data and piace,	nnar as stated and dua to tha	Causa(s)
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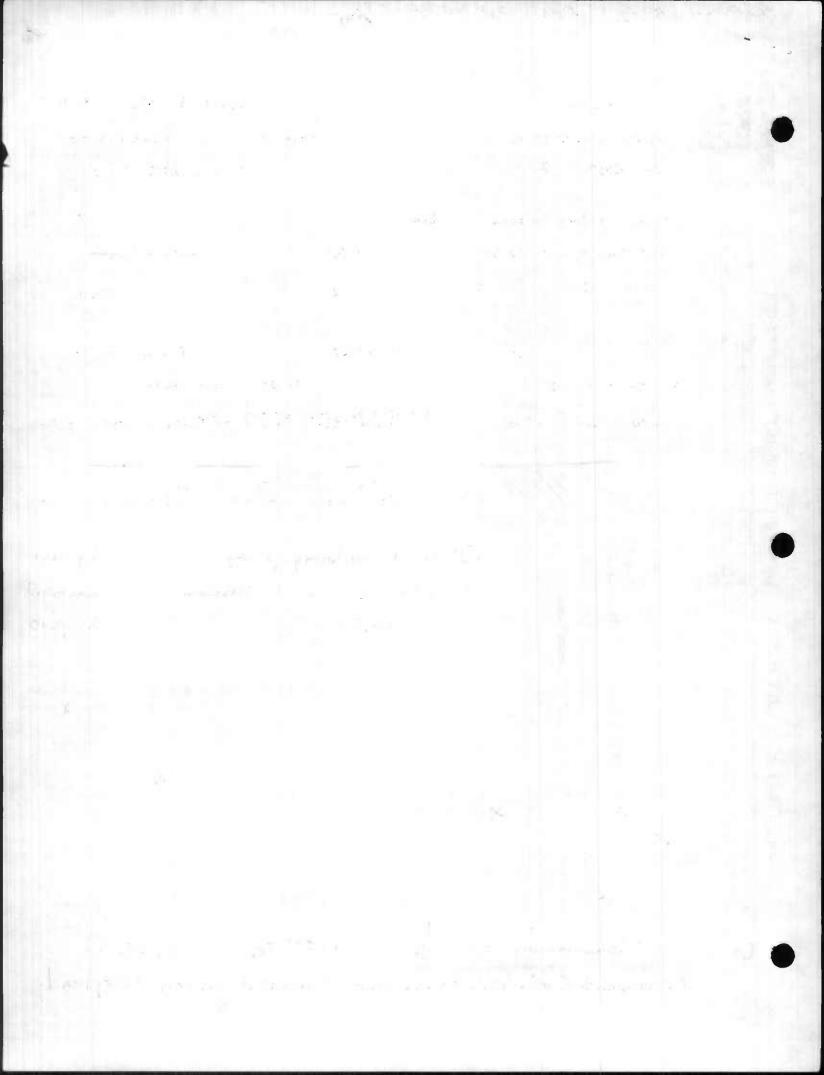
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er algnificant o	conditions co	ntributing to death I	but not res	ulting in the ur	ndertvina	causa niv	ven in Part I.	23b. Did	tobacco use co	ontribute to the car	use of death?
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ASAMOA KUET APRIL 28, 1999 530 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Amend #10q,20a,b,c,5/6/99,BMW,Montg.Co. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death April 28, 1999 Year **Physician** Kofi Asamoa 5:50 AM /Medical 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, giva street and number) 4c. County of Death Examiner Prince Georges Hospital Prince Georges If Undar 1 Yaer If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 578-72-8859 70 Yrs. Ghana Director Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Prince Georges Lanham 10g. Citizen of What Country? Ghana 10e. Street end Number 10f. Zip Code 3210 Reed Street #2633 20706 States Funeral 12. Was Decedant Evar in U,S. Armed Forces?
1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indien 11. Maritai Status Biack, Whita, atc. 1 ☐ Never Merried 2 🔀 Married 1 ☐ Yas 2 ☐ XNo Specify: Black Specify: à 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 nend Mental Hygiene.
Is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) Taxi Driver Transportation 18. Mother's Name (First, Middle, Melden Sumeme) 17. Father's Name (First, Middle, Last) George Kunsi Zigah Louise Akosia Dzebu 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Pages 1 end 2 Health Item 27 Kwami Asamoa (Son) 20 Stubblefield Rd., Waynesboro, Virginia 22980 20b. Place of Disposition (Neme of cometary, crematory or other plece)
E.P. Cemetery 20c. Location - City or Town, State 20e. Method of Disposition Date 1X Burial 2 Cramation 3 Removal from State ò 6/28/99 Taviepe, Ghana 4 Donetion - 5- Other (Specify) unknewn unknown 21. Signature of Fefferal Service Ligarian 22. Nama and Addrass of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012 Part. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heef fellure. List only one cause on each line. Approximete Intervai Between Onset and Deeth Physician /Medical Immediate Cause (Final ilaied Curdiomyopaky diseese or condition resulting in death) Lycyrs Examiner Examiner End Stuge Ranul diseas physician and the burial-tran Sequentielly list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Dua to pras a consequenca of): Division of Vital Records, P.O. Box 68760, 20 years Physician/Medical 88 use 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by the 3 Probably Unknown 1 Yes 2 No by 24b. Were eutopsy findings evailable prior to 24e. Was en autopsy performed? Completed completion of causa of deeth? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicat examiner?

1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatiant 2 ER/Outpatient 3 DOA funerai 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending s effer death. 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 29a. Certifier 1🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, end due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted. To the Vithin 2 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifiar 29c. License number D48042 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Mohammad Sarfarazi, Prince George's hospital, Cheverly Maryland. 31. Date filed (Month, Day, Year) MAY 0 4 1999 32. Registrer's Signature Registrar



State

Registrar

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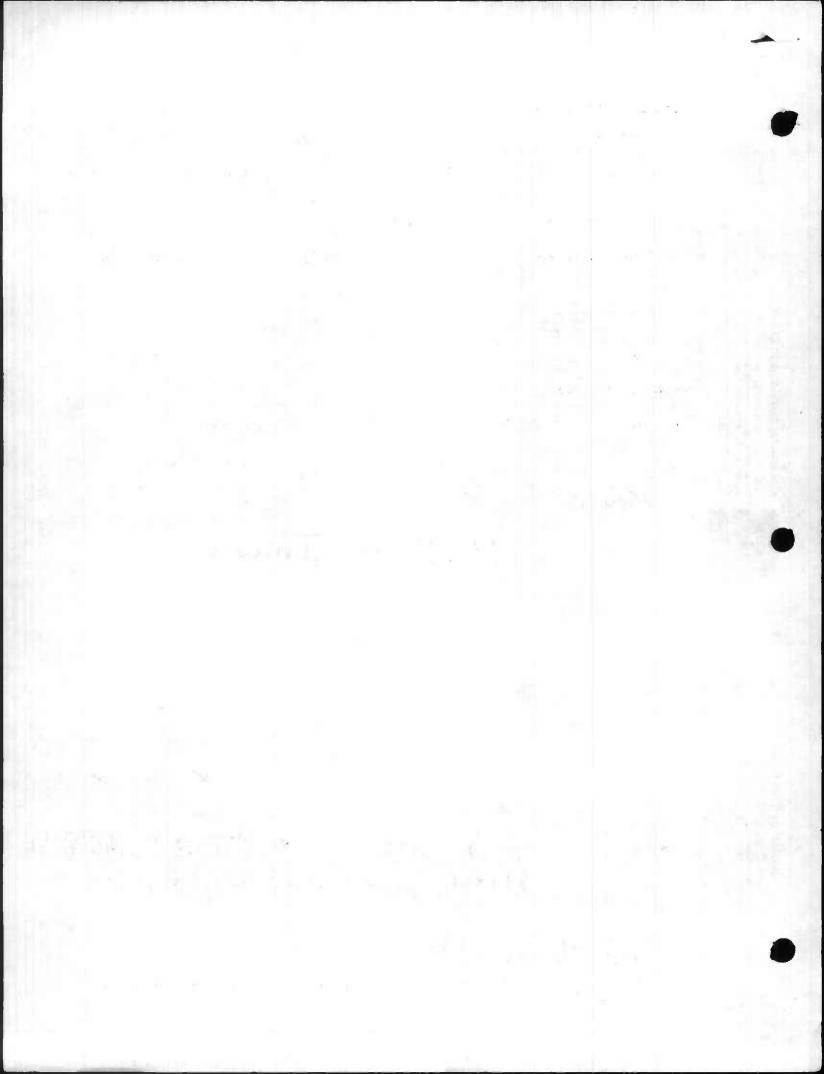
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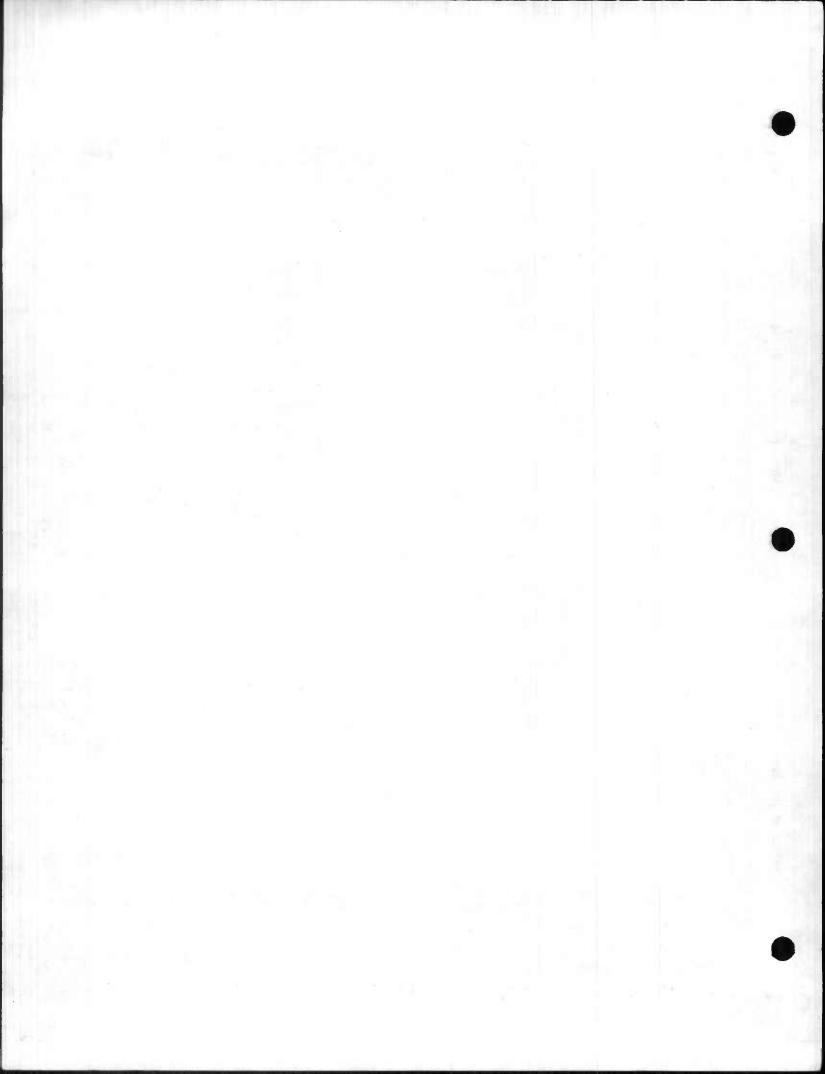
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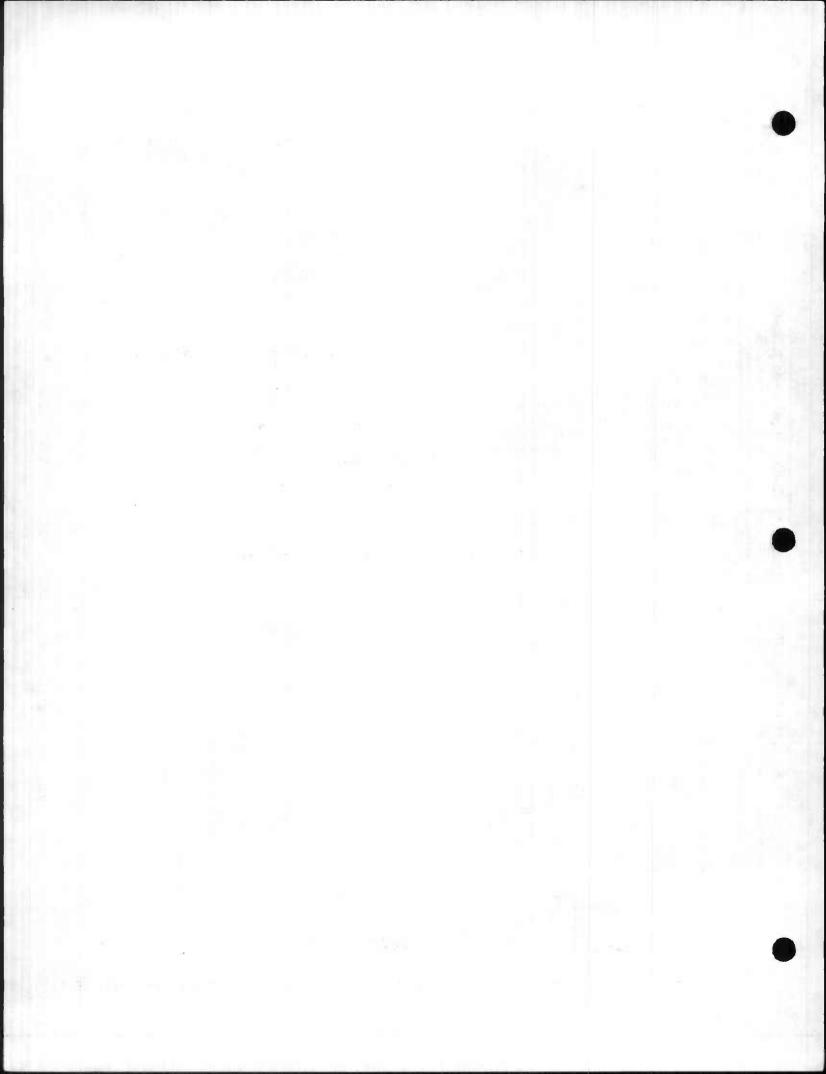


State of Maryland / Department of Health and Mental Hygiene

			C	ertificat	e of D	eath		Reg. No.	5	2006
	1. Decedent's Nama (First, Middle, Las	i)					2. Data of De Month	f Death 3. Tima of		
Physician /Medical	Luciana R. Bartol	.etti					May 2,			
Examiner	4a Facility Nama (If not institution, giva	street and number)			4b	. City, Town, or	Location of Death		of Death	0.50
Funeral Director	577-56-2003		last birthd	Months		heaton If Undar 24 Hrs Hours Min		Day, Year) Country)		
12	Usuat Residence of Decedent 10a. Stata 10b. County	10c, Ci	ity, Town or	Location					16	Dd. tnside City Limi
or items 23e or 28e-f ehow import ment be notified at 7 Funeral Director	Maryland Montgome			er Spri				10g. Citizen of V		1□Yas 2√P
0 0 0 0	4011 Randolph Roa	v.d.			20	902		T. 1		
at, or terms 234 territors must by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Evar in U Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas:	J,S. 1	3. Was Deced If Yas, spec	dent of His cify Cuban	ispanic Origin? (Specify Yas or No- n, Maxican, Puarto Rican, etc.)		Specify:		atc.
"natural", adjest Exe	15. Decedent's Edu			cedent's Usua			41	16b. Kind of Bi	White usinass/Ind	
nt the medical	(Specify only highest grad	ta completed) College (1-4or 5+)	- (G	a. DO NOT us	rk done di se retired)	iring most of wo	orking			
omp de	12	College (1-101 3+)	Neve	er Work	ced			N/A		
e Company	17. Father's Name (First, Middle, Last)					18. Mothar's Na	ma (First, Middla,		na)	
treumatic event,	Leone Bartoletti		Domen	ica Bucc	-					
reumetic ev	19a. Informant's Name/Relationship (T)		19b. M	aiting Addrass	(Street a		lural Routa Numb		State, Zip	Code)
other s	Teresa Zarrelli 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ If 4 □ Donation 5 □ Other (Specify,	Removal Irom State	Place of Discematary, of	sposition (Nan crematory or o	na of other place)	lver Spr	20c. Location -	- City or Tov	20906 wn, Stata
Important: If it is not injury or or one	21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compshock, or heart failura. List only o	tional	I	22. Nama an Francis 500 Uni	d Address J.	ol Facility Collins ity Blv	Funeral	Home,	Inc.	
ysician Medical aminer	Immediata Causa (Finat disease or condition resulting in death)	Myocardial Due to (c	or es e con	ction sequence of):				-	1	
iding physician and use as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (c	ism or as a cons	sequence of):						
d for use	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the	a underlying c	alica nive	n in Part I	23h. Did	Iohacco usa co	entribute to	the cause of dear
igned by the ettend be deteched for us. by Physician/										ably 45 Unknown
2 should pieted								an autopsy rmed?	con	ra autopsy finding nilable prior to mplation of causa death?
page page							10	Yas 2K No	1	Yas 2 No
rector, par rector, par Be Co	25. Was case referred to medical axaminer?						ath (Check only o	nne)		
this of the control o	1 ☐ Yes 2 ☑ No		ER/Outpa		_	4771 Ministrig	Homa 5 ☐ Rasi	dence 8 DOth	ner (Specify)
To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (27. Manner of Death 1 Natural 5 Pending 2 Accident invastigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injur	b. Tima of Injury M 28c. Injury at Work? M 28d. Describe how injury occurred 1 Yes 2 No						l Routa Number.
Certi	4 Homicide detarmined	28e. Place of Injury - At h building, atc. (Special	(b) 				City or To	vn, State)		
the Funeral inpletely filled Aedical Co	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examine and manner stated.	owiedge, de etion and/or	invastigation,	, in my opi	nion, death occ	e, end due to the urred at the tima,	dete and place,	and due to	the cause(s)
To the comple	29b. Signature and title of certifier	11 6		290	. License	number		29d. Data signe	d (Month, E	Jay, Year)
	Mouns	V. sosyu	1	D	4733	0		May 2.	1999	
	30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Tyr						=.d.d.d.	
State Registrar	30. Name and address of person who control of the second o	M.D. 50 W. 32. Registrar's Signa	. Edm	onston	Driv		ville, M	aryland	208	52



1.0	Decedent's Neme (F	iret Middle Leet			Cen	tificate of	Death	2. Date of De	Reg. No.		2 Time of F	lo ath		
an	Helen			ston				Month	Dey	Yeer				
al 4a	Facility Name (If no	S .					4b. City. Town, o	April Location of Deat			10:30	am_		
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	ocial Security Numb				last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Dete of Bir		9	/			
	305-14-05	0.0	M 2√2 F	89	Yrs.	Months Days	Hours Mir	July 4	, 1909	Color				
	. State 10	b. County		10c. Cit	y, Town or Loc	ation				10	d. Inside City	Limits		
M.	aryland 1	Montgome	rv	Ro	ckvill	2					1 ₹ Yes	2 □ No		
2	. Street and Numbe		. L y	I KO	CRVIII	10f. Zip Code			10g. Citizen of V	What Count	ry?			
	1801 East	Jeffers	on Stree	t. #6	23	20852	,	20.00	United	State	20			
11.	Merital Status		12. Was Decedent Armed Forces	Ever in U.	S. 13. W	as Decedent of	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No	- 14. Rac	e - America	n Indian,			
	1 ☐ Never Married 3 ☐ Widowed 4 🗹		1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:			☐ Yes 2 No		110 1 10211, 010.7	Specify	,				
E		Decedent's Edu			16a. Decede	ent's Usual Occu	pation		16b. Kind of B					
E	(Specify of lementery/Seconda	ry (0-12)	completed) College (1-4or	5+)	life. D	O NOT use retire								
_			4		Tea	cher / I	ibrarian		Educat					
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	a Informant's Name John Pera			POA)			t and Number or F				J00e)			
-	. Method of Disposit		(20b. P	lace of Dispos	Street ition (Name of	•	lashingto	20c. Location -	20009 City or Toy	m. Stata			
	1□ Burial 2 🖾 C	remation 3 DR	emovel from State			e Cremat		5-1-99				nd		
21.	4 □ Donetion 5 □ Signeture of Funere		90/	One		Name and Addr			Deresvi	116,	naly1a	110		
	for.	1/hu			F	app Fun	eral Ser				2 0			
234	a. Part1. Enter the d shock, or heart fa	lisease, or compli	cations that cause	d the deat	h. Do not ente	33_Gist	Avenue,	Silver ac or respiretory 6	Spring,		Approximate			
Sex Sex	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease or injury Cause).													
tha	use (Disease or injui t initieted events ulting in death) Last			Due to (or	as a consequ	ence of):								
Peri	II. Other significan	nt conditions con	tributing to death I	but not resi	ulting in the un	derlying cause g	iven in Part I.	23b. Did	tobacco une co	ntribute to	the cause of	death?		
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_							<u> Hac</u>	24a. Wes	an autopsy ormed?	ava	re autopsy fin ileble prior to apletion of ca eath?			
								10	Yes 2 No	1 🗆	Yes 2N	lo		
25.	Wes case referred (examiner?		la ancière la					eath (Check only	one)					
27.	1 ☐ Yes 2 ☐XNo Manner of Death 1 ☑Netural 5	Pending Investigation	28a. Date of Inj (Month, Di	ury	ER/Outpatient 28b. Time of Injury	28c. Inju		Home 5 N Res 28d. Describe	idence 6 Oth how injury occur)			
	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place of in building, e	ijury - At ho lc. (Specif)	ome, farm, stre	et, factory, office			(Street and Numb wn, State)	per or Rural	Route Numb	er,		
29a	Certifier 1 (Check only 2 one)	Certifying Phys Medical Examin	ician: To the best ner: On the basis of and manner st	of examinat	wledge, death tion and/or invo	occurred at the testigation, in my	ime, date and plac opinion, deeth occ	ce, end due to the curred et the time,	cauae(s) and ma date end place,	anner es sta and due to	ited. the ceuse(s)			
29b	. Signature and title	of certifier		.0.	1	29c. Licen	se number		29d. Date signe	d (Month, L	Day, Year)			
	Katt	raren	2 K.0	Til	lie m.	D	53244		April 3	0, 19	99			
30.	Nama and address	of person who co	mpleted cause of	death (Item	23a) (Type, P	rint)	Dollar -							
K	atharine	R. Lill:	ie, M. D.	, 1	1140 Ro	ckville	Pike, #	348, Ro	ckville.	MD	20852			
e ^{31.}	Dete filed (Month, D			rar's Signa		,								
ar	MAY	0 3 1999	- Bolon	and	14		0 .							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7,5/3/99,BMW,Montg. Co Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** APRIL 27, 1999 HONORIA E. BAILOR-CAULKER 8:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 75 Director May 15, 1923 N/A Sierra Leone Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow adical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1701 Mt. Pisgah Ln, #12 20903 Sierra Leone Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Example Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2X Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Natural Ruler Sierra Leone 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 89 Priscilla Caulker George Remmie 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Mt. Pisgah Ln, #12, Silver Spring, MD 20903 Chad Bailor/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State Village Cemetery May 16 Sierra Leone 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21 Signature of Funeral Service Licenses lla Donnel O 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner ician and burial-transit that the death carificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician as the burial Box 68760, Physician/Medical Due to (or as a consequence of) 080 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 1 Yas 2 LNo 3 Probably 4 Unknown Records. ģ The law requires 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 201N 1 ☐ Yes 2 ☐ No certificata Division of VItai Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Napatient Certification: To 1 TYes 2 TLN6 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? thin 24 hours after death.
The Funeral Director: After Vately filled in by the 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the p 29c. License number 29d. Date signed (Month, Day, Year)

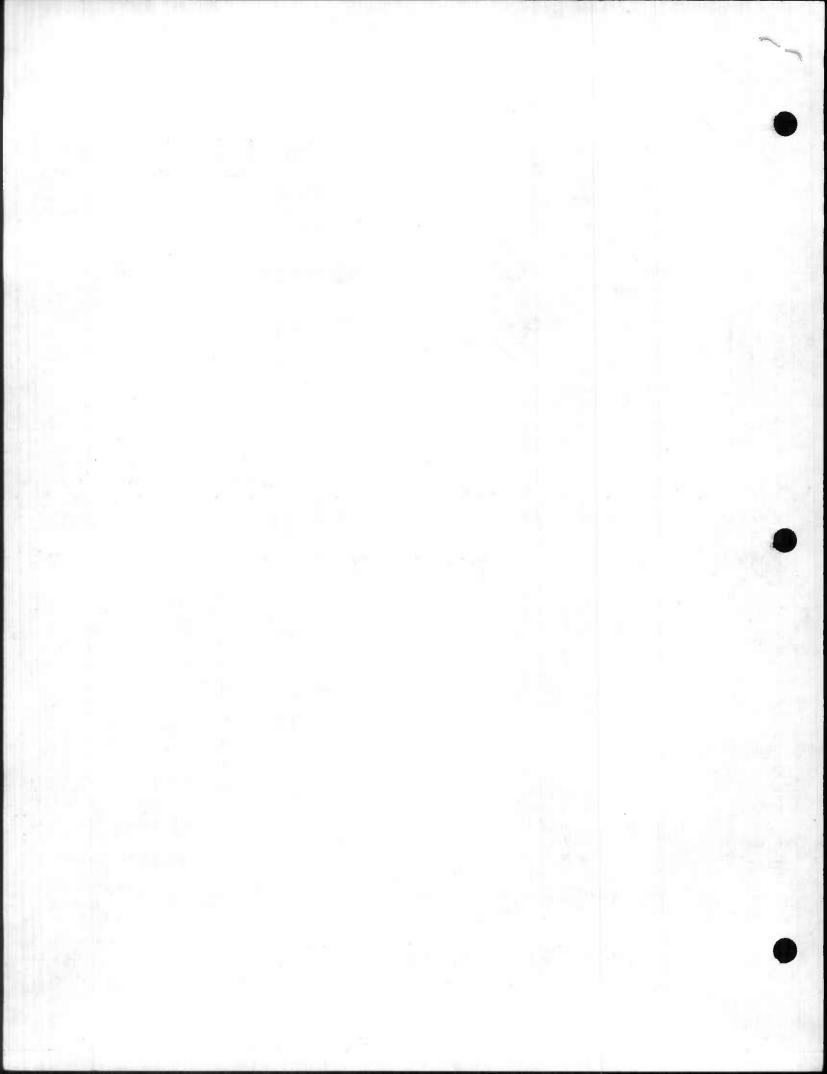
State Registrar

31. Date filed (Month, Day, Year) MAY 03 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

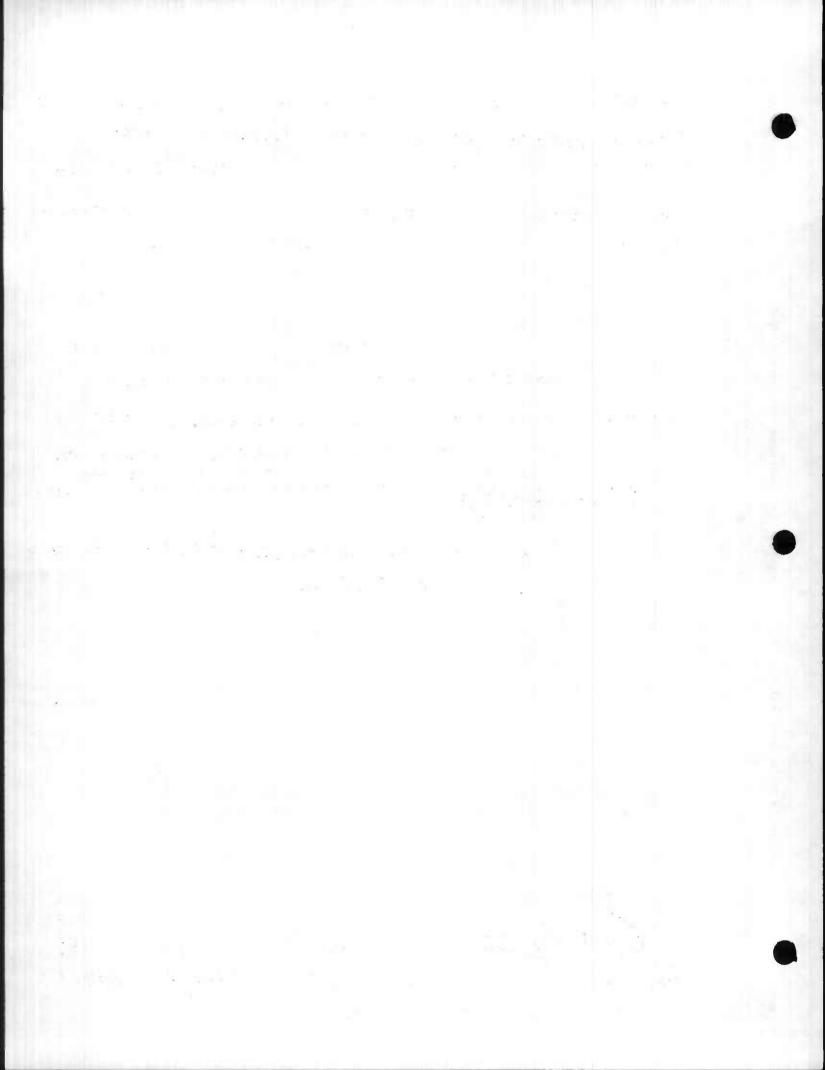
29b. Signature and title of certific

FARRAGUT AVE KERSING TON, MD 20895 3720 ROSENBAUM 32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 99 15955

ysician			Certini	cate of Death	Re	g. No.	
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Medical	JOHN	7.	DK	AUNING	APRIL	29 19	99 0246
miner	4a Facility Name (If not Institution, give	/	1.16		or Location of Deeth	4c. County of	Death
	5. Sociel Security Number 6. S		DICAL SU s. last birthdey) If L	Inder 1 Year If Under 24 F		70/	. Birthplece (State or Foreign
		XM 2□ F 85	Man Man		in. (Month, Dey,	Year) 1913 M	Country) IARYLAND
1	10a. Stete 10b. County	10c. 0	City, Town or Location				10d. Inside City Limits
to	MD. CARROL	L :	TANEYTOW	4			1 ☐ Yes 2X No
i Director	10e. Street and Number 3307 UNGER RD.		10	f. Zip Code 21787	10	g. Citizen of Whe	et Country?
by Funeral	11. Meritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Detes:		Decedent of Hispanic Origin? specify Cuben, Mexican, Pues 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Bleck,	American Indien, White, etc.
P	15. Decedent's Ed	fucation	16a. Decedent's	Usuei Occupation	drine	6b. Kind of Busin	ness/Industry
Completed	(Specify only highest gre Elementery/Secondary (0-12)	College (1-4or 5+)		of work done during most of of OT use retired)	working		
200	7		1	FARMER		AGRICU	JLTURE
e e	17. Father's Neme (First, Middle, Last)		DD A HMTNC		Neme (First, Middle, M		
10		AS GORDON I			A CATHER		
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- 1	EMMA VIOLA BRAU 20e. Method of Disposition		3307 UI	NGER RD., TA		TID .	787 ty or Town, Stete
	1 Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specific	Removel from State	cemetery, cremetory	or other piece) MEM . GARDENS			URG, MD.
1	21. Signature of Funeral Service Licen			ne end Address of Fecility F			
	D B V	11 PX		E. MAIN ST.			
	23a. Part1. Enter the disease or com shock, or heart failure. List only	olidations that calls of the de					Approximate Intervel Between
Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. CARDIDue to	o (or es e consequence	ARDIAL I e ot): H, LURE e ot):	N THE	17810	Onset and Death 30 MIN
edicai	that initiated events resulting in death) Last	C. Due to	(or es e consequence				
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by Physician/M	L					s 2 No 3	ibute to the cause of death? Probably 4 Dunknown 24b. Were eutopsy findings aveilable prior to completion of cause
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Please Type or Print in Black Indelible Ink. Assure All Copies Are LegIble. State of Maryland / Department of Health and Mental Hygiene Hem #26 Per Physician 5-16.99 CCHD FCB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month ALVERTA BLANCHE BERRY MAY 3 1999 8:14 PM 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death CIVISTA MEDICAL CENTER LAPLATA CHARLES 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stet Country) VIRGINIA If Under 24 Hrs. Hours | Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 79 217-32-1853 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MARYLAND CHARLES WALDORF 1 ☐ Yes 2 💢 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3669 OLD WASHINGTON ROAD 20602 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specity: WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middla, Maidan Sumame) 17. Fathar's Nama (First, Middle, Last) ROBERT L. ANDERSON NANNIE BELLE MOWLES 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) JAMES HORACE BERRY, SR./HUSBAND 3669 OLD WASHINGTON RD., WALDORF, MARYLAND 20602 20b. Place of Disposition (Name of ST . PAUL ST EPISCUPAL 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHURCH CEMETERY MAY 7, 1999 WALDORF, MARYLAND 21. Signature of Fyneral Servicy Lightsee 22. Name and Address of Fecility JOHN P. KNISLEY THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156 23a. Part1. Enter tha disease, or complications that caused tha daath. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) CARDIOVASCULAR COLLAPSE 2 HRS Dua to (or as a consequence of): ATHEROSCLEROSIS Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ALZHEIMER'S 24a. Was an autopsy parlormed? 24b. Wara autopsy findings available prior to completion of cause of daath? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physiclan /Medical Examiner

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Box 68760,

P.O.

Division of Vital Records,

Physician

Examiner

Funeral

Director

th and Mental Hygiene.
7 is merked other than "natural", or items 23s or 28e-f show traumstic event, the Medical Examiner must be notified at

and Mental H ammarked off

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n

/Medical

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Funeral

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Completed

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medical

> 25. Was cese referred to medical examiner? 1□ Yes 2 No

5 Pending Investigation

6 Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

26. Place of Daath (Check only one)

Othar: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29a. Cartifiar (Check only one)

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homleida

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to tha ceusa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha causa(s) and menner stated.

29b. Signatura and titla of certifiar

29c. License number

29d. Date signed (Month, Dev. Year)

M.D. P.C

129646

1 Yes 2 No

05,04,

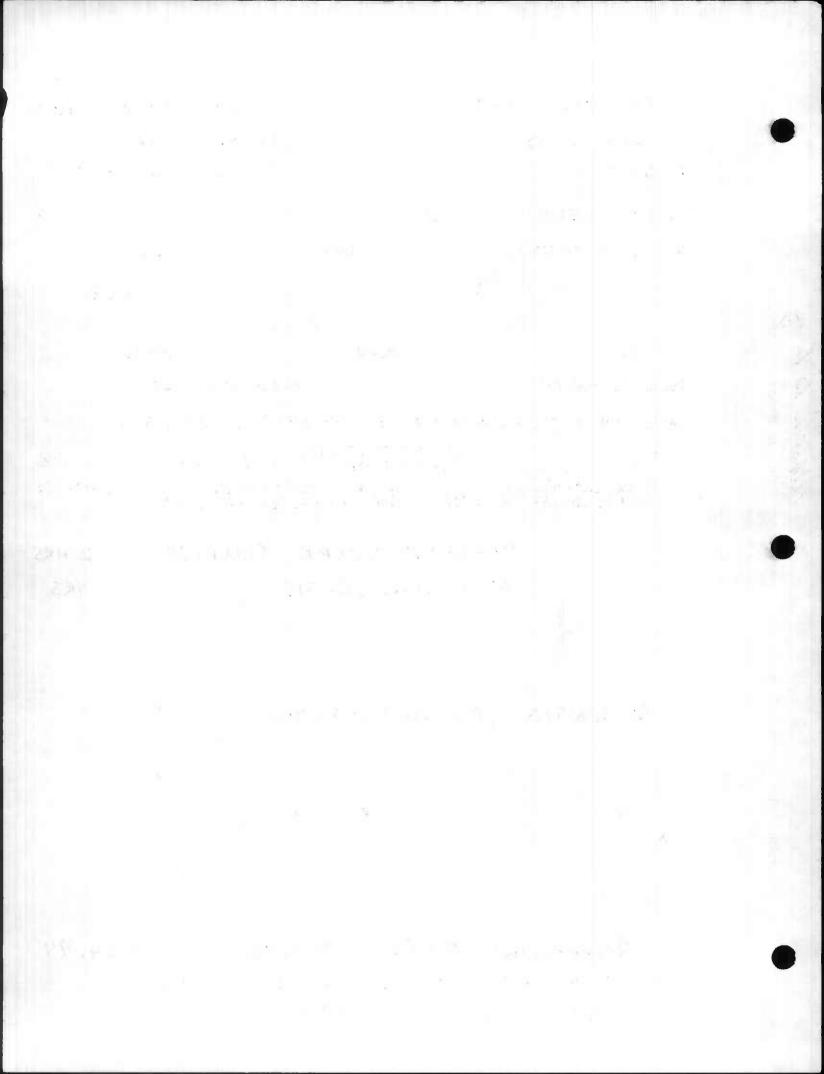
30. Name and aderass of person who completed cause of death (Item 23a) (Type, Print)

JOEL SEWCHAND MD 118 LA GRANGE AVE. P.O. BOX 975 LAPLATA MD. 20646

Registrar

31. Date filed (Month, Day, Year) MAY 07 32. Registrar's Signature





State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

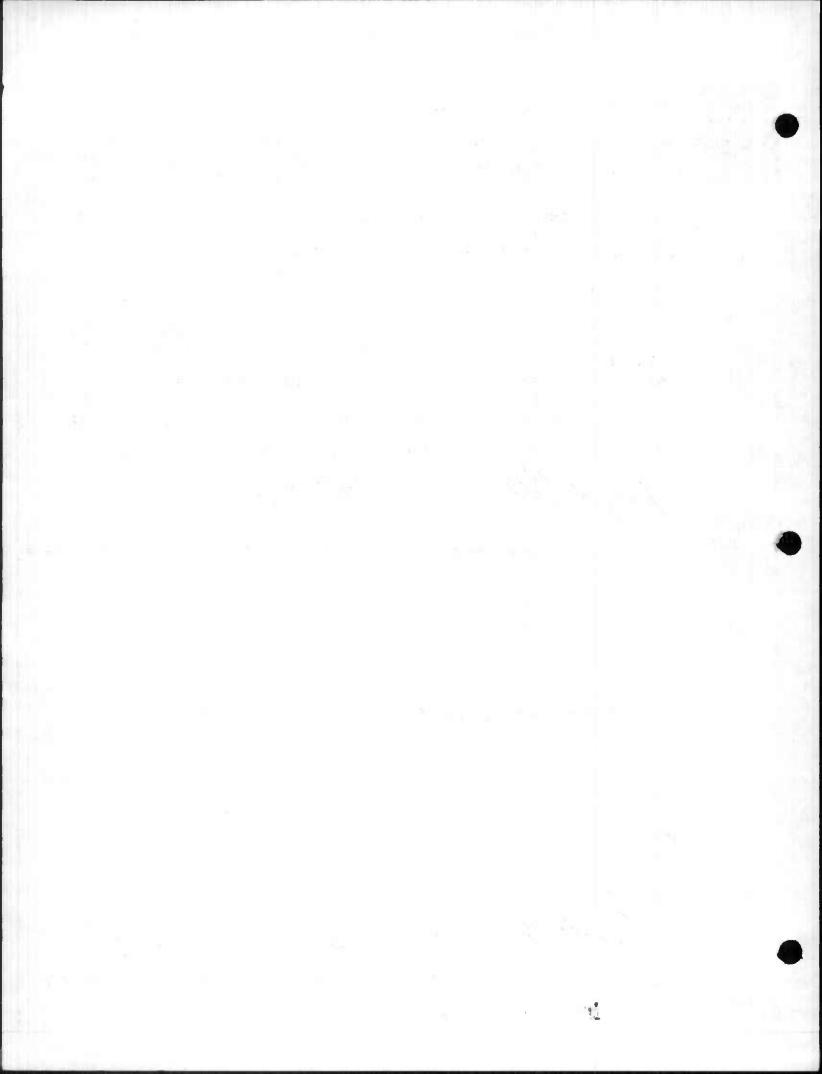
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Maryland a-f show	tor	Usual Rasidance of Decedant 10a. Stata 10b. County MD • FREDE	ERICK	10c. City, Town or	Location EDERICK					nside City Limits
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permit. Pages Department of Important: If it any injury or	X	21. Signetura of Funeral Servica Licar	Colleis	Ç	22 Nama and Ad GARY L. 110 WES	ROLLINS T SOUTH	FUNERA ST. FRE	L HOME	2170	1
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th certificate be executed ending physician and r use es the bunal-transit	n/Medicai	Saquentielly list conditions, if any, laading to immadiata causa. Entar Undardying Causa (Disaasa or injury that initieted events resulting in daath) Lest	c	Dua to (or es e cons	aquanca of):					
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al or Attending s after death. is Director: After ad in by the fune	27. Mennar of Death Substitute			ury - At homa, farm, s c. (Specify)	straat, factory, offi	СӨ	28f. Location (S City or Town		er or Rural Rou	uta Number,
id on	edical (29a. Cartifier (Check only one) Certifying Ph	yalcian: To the best niner: On tha besis o and mennar st	axemination end/or	ath occurred et the invastigation, in m	tima, data and place y opinion, death occu	e, and dua to tha curred et tha time, d	ausa(s) and mai lete and placa, a	nner es steted and due to the	ceusa(s)
he Hospital in 24 hours he Funeral ipletely filled	9	1					T.			
To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Mec	290. Signature and title of certified	Cound	1 70		31761	2	9d. Date signed	Month, Day,	Year)

State

Registrar

MAY 0 5 1999 >



Amended line 19a Fchd, KS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician	
/Medical	
Examiner	

ELIZABETH

Funeral Director

Director

Funeral

py

7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at death permit. Pages 1 and 2 should be filled within 72 hours effer a Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "naturel", or item any injury or other traumatic event, the Medical Exemplant

Baltimore, Maryland 21215-0020

Physician /Medicai Examiner

Examiner physician end s the buriel-trans Division of Vital Records, P.O. Box 68760, Physician/Medical the signed by i þ Completed certificate Be 10 this After

Hospital or Attending Physician: 24 hours after death. To the To the Comple

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year BARTLEY BUTTON May 5:15 pm 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Hartfields at Frederick Walkersville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthdev) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖾 F 94 181-38-4255 June 13 1904 Ohio Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits MD Frederick Adamstown 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zlp Code 1607 Buckeystown Pike 21710 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indien, Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Interior Design/ Elementary/Secondary (0-12) College (1-4or 5+) Domestic 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Murray Hill Bartley Ellen Campbell 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Decedent Joan B. Strawson 1607 Buckeystown Pike Adamstown, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5/5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darnestown Presbyterian Darnestown, MD 21. Signature of Funeral Servica Licensee 22. Name end Address of Facility Hilton Funeral Home Will CHill Barnesville, MD 20838

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Atheroscheroric CARDIOVASCULAR Misaar years Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evellable prior to completion of cause of death? 24a. Wes en autopsy DEMENTIA WYPOTHYROIDSM

25. Was case referred to medical
examiner? 1 Yes DEVACCIONE (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

29e. Certifier

Naturel

2 ☐ Accident 3 Sulcide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

1 ☐ Yes

2 No

29b. Signature and title of certifie

5 Pending

Investigation

6 Could not be determined

29c. License number

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29d. Date signed (Month, Day, Year)

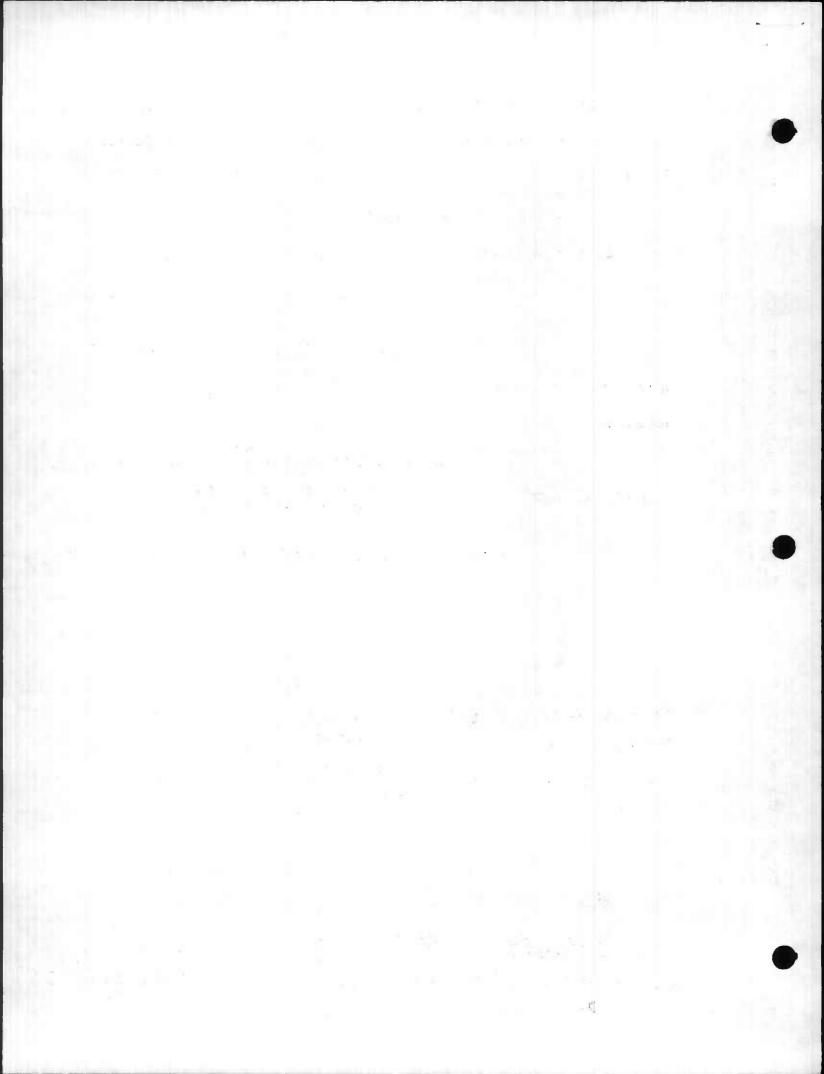
28f. Location (Street and Number or Rural Route Number, City or Town, State)

of death (Item 23e) (Type, Print)

1999 Registrant Signature

State Registrar

edicai



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth 3. Time of Leath May 4, **Physician** 1999 5:30 am Lula Franklin Creighton Baker /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Algonquin Rd. Cambridge I If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) Dorchester if Under 1 Yaar Months Deys 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplaca (Stete or Foreign Country) Months 1□M 2X F Yrs 217-48-6246 95 June 16, 1903 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Director Maryland Dorchester Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral l Algonquin Rd. 21613 U.S.A. 14. Reca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Dacedent of Hispenic Origin? (Specify Yes or No-tf Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Milford Franklin Creighton Eliza Ella Adams 19e. Informent's Neme/Relettonship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Creighton/Brother 107 Willis St., Cambridge, MD 21613 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Crametion 3 □ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Dorchester Mem. Pk. 5-6-99 Cambridge, MD 22. Neme end Addrass of Fecility Curran-Bromwell Funeral Home, P.A. Called Horrad concivel 308 High St., Cample of dying, such as cerdiac or respiratory arrest, 308 High St., Cambridge, MD 21613 Sart. Enter the disease, or complications that caused the death, shock, or heart adjust. List only one cause on each line. COLITIS Immediete Ceuse (Finel disaase or condition resulting in death) ISCHEMIC Due to (or es a consequence of): Examiner 4THED SCLEDOSIS Sequentietty list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Dua to (or es e consequenca of): Physician/Medicai Due to (or as e consequença of) resulting In deeth) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE MEART FAILURE p 24b. Were eutopsy findings available prior to completion of causa of death? Completed 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yas 20 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. injury et Work? 1 Maturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 113 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner steted. Medical 29e. Certifier (Check only one) 29b. Signeture and title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) Michael a. D-16609 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar MICHAEZ

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

d 2 should be filed within h and Mental Hygiens. 7 is marked other than "r filed within

Department of Health a Important: If Item 27 is any injury or other tras 9059.

Physiclan

/Medical

Examiner

physician end the burial-transit certificete be executed

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this funeral

After !

n Hospital or Attanding n 24 hours after deeth. Funeral Director: Aft bletely filled in by the fun

To the Hosp within 24 hou To the Fune completely fi

Attanding

page 2 s

Box 68760,

P.O.

Division of Vital Records,

The law requires that

Pages 7

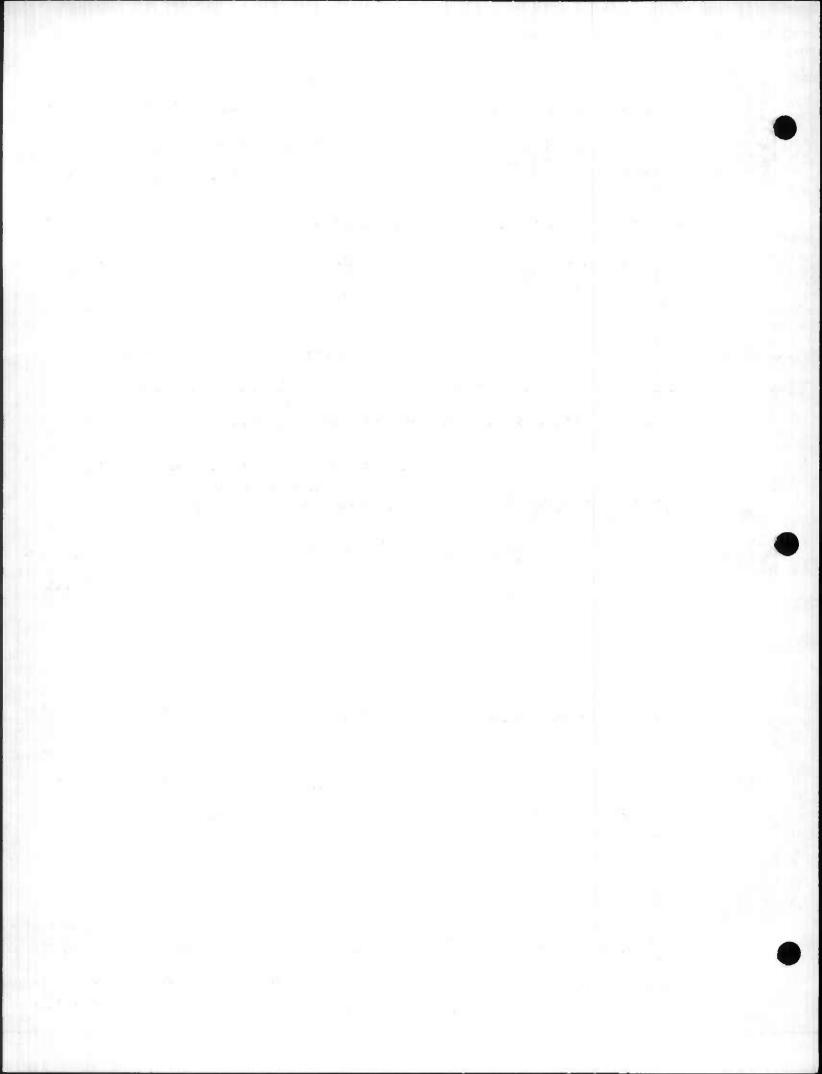
31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture MAY 0 6 1999

Moskewicz

BYEN ST.

21613

CAMBRIDGE



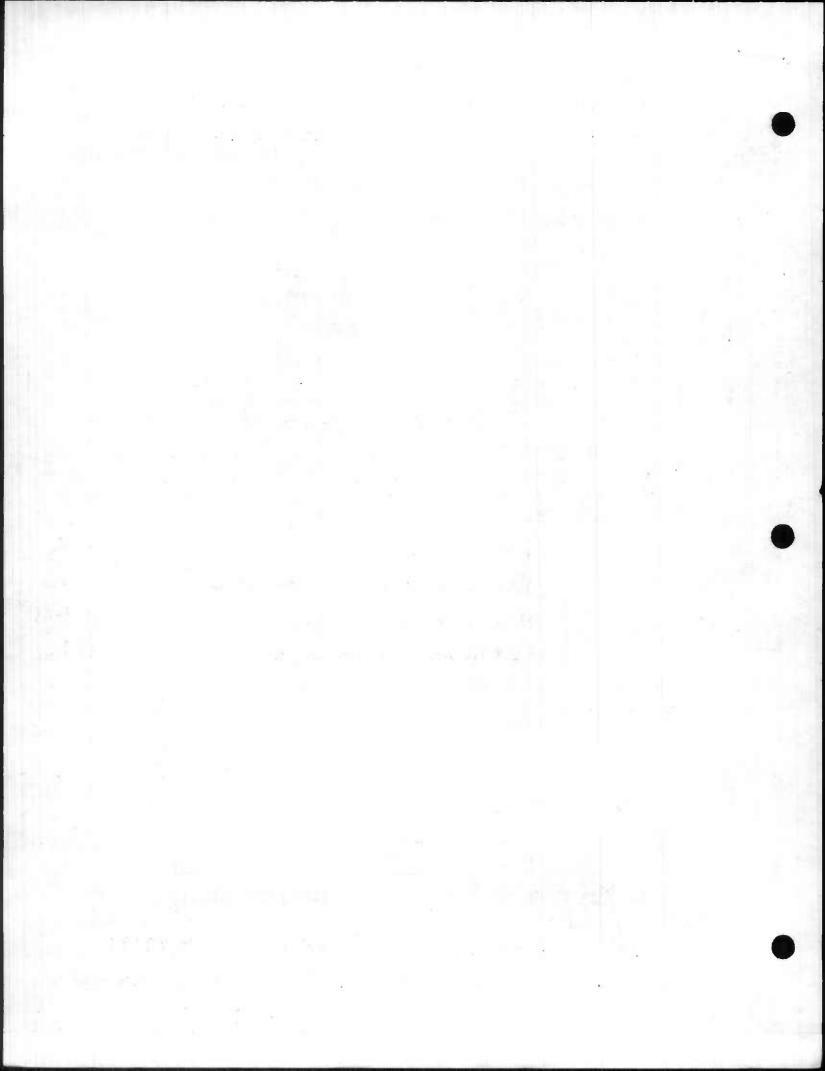
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	of Death		Reg. No.	10000			
1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of Deat	h		
Dierdra Nicole	Campbell				April	29, 1999	Year 11:21 PM	1		
4a Facility Name (If not institution, give st	treet and number)			4b. City, Town, or						
Holy Cross Hospita	1			Silver S			gomery			
none	7. Age (h	n yrs. last birth Y	Months Da		8. Date of Bir (Month, De April	th 29, 199	9. Birthplace (State or Fore Country) Maryland	aign		
Usual Residence of Decedent 10a. Stete 10b. County	10	c. City, Town	or Location				10d. Inside City Lin	nits		
Maryland Montgome	ery S	Silver	Spring				1 ☐ Yes 2√	No		
			10f. Zip Cod 2091			10g. Citizen of V				
11. Marital Status 1	2. Wes Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	r in U,S.	13. Was Decedent of Yes, specify C	of Hispanic Origin? (Scuban, Mexican, Puerl No Specify:	pecify Yes or No to Rican, etc.)	Blac	e - American Indian, ck, White, etc.			
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(ife. DO NOT use rea	ne during most of wo	rking	16b. Kind of Br	usiness/Industry			
17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Suman	ne)			
Rodney Anthony Cam	npbell			Nicoll	Lee Kin	g				
19a. Informant's Name/Relationship (Typ		19b.	Mailing Address (Str	eet and Number or Ri	ural Route Numb	er, City or Town,	State, Zip Code)			
Rodney & Nicoll Caparents 20a. Method of Disposition 1 \(\tilde{\Omega} \) Burial 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) Re 4 \(\tilde{\Omega} \) Donetion 5 \(\tilde{\Omega} \) Other (Specify)	-	20b. Place of I cemetery	14 Maine Disposition (Name of crematory or other) f Heaven	Avenue, Si	Date	20c. Location -	city or Town, State Spring, Mary			
21. Signeture of Funerel Service Licansed	е	oacc o		dress of Fecility eral Servi			oping, nary			
Cand a	0.0			Avenue, S			Marvland 209	10		
Immediate Cause (Final disease or condition resulting in death) e.	PNEVMS	o to (or as a co	nsequence of):				Approximete Intervel Between Onset and Death	,		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying				AL empl	Irsoma		Stro			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	HVALLNE	mon		DUENE		400	11 Hrs	5		
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						an autopsy omed?	24b. Were autopsy lindin available prior to completion of cause of death?			
					10	Yes 2 No	1 □ Yes 2 VNo			
25. Was case referred to medical exeminer?					eth (Check only	one)				
1 Yes 2 No	ospital:	2 ER/Outp	elleni 3L DOA		lome 5 ☐ Resi					
27. Manner of Death Tetural 5 Pending	28a. Date of Injury (Month, Day Ye	njuryat Nork? I∐Yes 2∐No	28d. Describe	how injury occur	red					
27. Manner of Death 1 Diffetural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	3 Suicide 4 Homicide Could not be determined Suicide 4 Homicide City or Town, State) 286. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)									
29a. Certifier 1 Certifying Physic	clan: To the best of mer: On the basis of exa	amination end/					anner as stated. and due to the cause(s)			
29b. Signature and little of certifier		-2	29c. Lio	ense number		29d. Date signe	d (Month, Day, Year)			
> St-16.8	n	p	D	20524		4/29	199			
30. Neme and address of person who come STEUS P. WYNER Y			ype, Print)	to forust G	LEN RD	SHILEA	PRING nd			

DHMH 16 Rev 6/95

Registrar

MAY 071999



State of Maryland / Department of Health and Mental Hygiene

Physician //Medical Examiner GLORIA BUCKMAN CARRY Month MAY 2, 1999 7:15 4b. City, Town, or Location of Deeth LAYHILL CENTER SILVER SPRING MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 I M 2 N F Country) 9. Birthplace (State or For Country)				(Certifica	te of	Death		Reg. No.	1990		
CORTA BUCKMAN 48 Facility Name (if not metaloding particularly managed in the particular of the parti		1. Decedent's Neme (First, Middle, La										
46 Facility Hame of ford installations, give stated and managery 46 Facility Hame of ford installations, give stated and managery 47 Facility Hame of ford installations, give stated and managery 48 Facility Hame of ford installations, give stated and managery 49 Facility Hame of ford installations, give stated and managery 49 Facility Hame of ford installations, give stated and managery 49 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 41 Facility Hame of ford installations, give stated and managery 42 Facility Hame of ford installations, give stated and managery 43 Facility Hame of ford installations, give stated and managery 44 Facility Hame of ford installations, give stated and managery 45 Facility Hame of ford installations, give stated and managery 46 Facility Hame of ford installations, give stated and managery 47 Facility Hame of ford installations, give stated and managery 48 Facility Hame of ford installations, give stated and managery 49 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery 40 Facility Hame of ford installations, give stated and managery		GLOF	RIA BUCKMA	N CAR	RY							
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Total Content Total Conten	Funeral			(In yrs. last birth				8. Dete of Birt	h Year)	9. Birthplace (State or		
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The second complete of the second completed of the sec	E E		Armed Forces?		13. Wes Dec	edent of H ecify Cub	tispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Pican, etc.)	14. Race Black	- American Indien, k, White, etc.		
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196 Informent's NamoPhilationarity (Typo, Print) 196 Melling Address (Street and Number or Rural Route Number, City or Town, State, Zo Code) JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 200 Detection (Street and Number of Parall Route Number, City or Town, State, Zo Code) JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 200 Detection (Street and Number of Parall Route Number, City or Town, State 2 Code) JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 200 Detection (Street and Number of Parall Route Number, City or Town, State 2 Code) JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 200 Detection (Street and Number of Parall Route Number, City or Town, State 2 Code) JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 200 Detection (Street and Number of Parall Route Number, City or Town, State 2 Code) JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JEANIETTE C. PARSHALL/DAUCHTER 5.10.9 NORECK RD., ROCKVILLE, MD. 20553 JE	D . W											
JEANNETTE C. PARSHALL/DAUGHTER 5109 NORBECK RD., ROCKVILLE, MD. 20853 206. Method of Disposition 206. Method of Disposition 207. Marky 1's CEMBETERY 5/8/99 MILPORD, CT. 21. Signature of Furnel's services present 4 (Disposition 5 (Diffeer (Speciety)) 22. Signature of Furnel's services present 4 (Disposition 5 (Diffeer (Speciety)) 23. Signature of Furnel's services present 24. Part Eiter the disposes, or complications in the cused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inclined as Casuage (Final resulting in death)) 23. Part Eiter the disposes, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inclined as Casuage (Final resulting in death)) 25. Marky 1's CEMBETERY 36. Part Eiter the disposes, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, inclined as Casuage (Final resulting in death)) 26. Casual And And And And And And And And And And	To meto											
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4 □ Consisting 1 Superior of Ferror of Gasers or confidence of Consisting in the underlying cause given in Pert I. 21. Signature of Firemal Services/Description and caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Consistence r of	1 Burial 2 Cremation 3 Removel from State cemetery, crematory or other place)											
Section Sect	ury ury	4 Donetion 5 Other (Specific	y)	ST. N	IARY'S	CEME	TERY	5/8/99	MILFO	RD, CT.		
Sician collection Sici	20-8	21. Signature of Funeral Service Licer	1500		22. Neme a	and Addre	ss of Fecility					
28. Pent II. Enter the disease, or completations that caused the destit. Do not enter the mode of dying, such as cardiac or respiratory errost. Approximate informal between the mode of dying, such as cardiac or respiratory errost. Immediate Causa (Final disease or condition) By Cardian and Causa (Final disease or condition) By Cardian and Causa (Final disease or condition) By Cardian and Cardia	SESS	11/11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	1/2/1611	1600001	CITANET	mna :	DINTERNATION TO	OME D	A 10737	DDATE MO		
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use griffibute to the cause of d 1 Yes 2 No 3 Probably 4 Unit 1 Yes 2 No 3 Probably 4 Unit 1 Yes 2 No 1 Yes 2	ysician and ne burial-transit Ical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
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25. Wes case referred to medical axaminer?	Die be									completion of ca		
25. Wes case referred to medical axaminer?	ege ege							10	es 200 No	1 ☐ Yes 2 ☐ !		
27. Many fer of Death 1	or, p	25. Wes case referred/to medical					26 Place Dec	th (Check only o	ne)			
27. Maryler of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M	Sirect OB	axaminer?	Hospital:	a off EB/Out	ationt 200	OA Oth	nor t			or (Specify)		
Name and defined of person who completed cause of death (Item 23a) (Type, Print) JOHN J. MERENDINO, M.D. 4701 RANDOLPH RD. #216, ROCKVILLE, MD. 20852	and T.T		28a. Date of Injury	28b. Ti								
Name and defined of person who completed cause of death (Item 23a) (Type, Print) JOHN J. MERENDINO, M.D. 4701 RANDOLPH RD. #216, ROCKVILLE, MD. 20852	fun to			Year) Inj								
JOHN J. MERENDINO, M.D. 4701 RANDOLPH RD. #216, ROCKVILLE, MD. 20852	Director In by the	3 ☐ Suicide 6 ☐ Could not be	208. Place or injur	ry - At home, tem (Specify)	n, street, fecto	ory, office						
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Name and defined of person who completed cause of death (Item 23a) (Type, Print) JOHN J. MERENDINO, M.D. 4701 RANDOLPH RD. #216, ROCKVILLE, MD. 20852	8 -	200. Signature and title of certiller										
JOHN J. MERENDINO, M.D. 4701 RANDOLPH RD. #216, ROCKVILLE, MD. 20852	0									3,1999		
31. Dete filed (Month, Day, Year) 32. Registrar's Signature		Name and address of person who completed cause of death (Item 23a) (Type, Print)										
31. Dete filed (Month, Day, Year) 32. Begistrar's Signature					701 R	ANDO]	LPH RD. #	216, RO	CKVILLE.	MD. 20852		
	State			's Signature								

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Please Type or Print In Black Indellble Ink. Assure All (State of Maryland / Department of Health and Mel Certificate of Death 1. Decedent's Name (First, Middle, Last) 2.		
	Reg. No.	00000
	2. Date of Death	3. Time of Deeth
Walter Cameron, III	May 3, 1999	
4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Local		County of Death
20411 Cabana Drive Germantown	m M	lontgomery
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	8. Data of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
203-34-1467 54 Yrs. 0	October 20, 19/	944 South Carolina
10a. State 10b. County 10c. City, Town or Location		10d. Insida City Limits
Maryland Montgomery Germantown		1 ☐ Yes 2 No
10e. Street and Number 10f. Zip Code	10g. Cltize	zen of What Country?
20411 Cabana Drive 20876		United States
11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specifity Specify Cuban, Maxican, Puerto Ric	ify Yes or No-	14. Raca - American Indian, Black, White, etc.
1 Never Married 2 Married 1 Yes 2 No		
3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	3	Specify: Black
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grada completed) (Give kind of work done during most of working	16b. Kinr	nd of Business/Industry
(Specify only highest grada completed) Elementery/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)		
2 Programmer/ Machinist		hine Shop
17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Last)	(First, Middle, Maiden S	Surname)
Walter Cameron, II Pho	ozie Barr	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural F	Route Number, City or	Town, Stete, Zip Code)
Linda Nelms-Cameron/ Wife 20a. Method of Disposition 1	1999 20c. Local	cation - City or Town, Stata nesda, Maryland
M00335 Bethesda, Maryland 2 23a Parti. Enter the dinestal, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. Let only one cause on each line.	20814-3501 respiretory arrest,	Approximate Intervsl Between Onset and Death
disease or condition resulting in death) a. Hospital New York Consequence of:	, sease	15 415
Sequentially list conditions. Due to (or as a consequence of):		20415
if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of):		
d		
Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco u	uaa contribute to the cause of death?
Chronic renal failure		
	24a. Wes en autops performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
		No 1 Yes 2 No
25. Wes case referred to medical examiner? 26. Place of Death (
1 ☐ Yes 2 ☑No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	ne 5 Residenca 6	
1 Naturel 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation 3 Suidide 6 Could not be	8d. Describe how injury	
3 ☐ Suicide 4 ☐ Homicide See Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify)	8f. Location (Street and City or Town, State)	d Number or Rural Routa Number,)

/Medical Division of Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

Within 24 hours effect death.

On the Funeral Director: After this certificate has been signed by the attending physicien and completally filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Completed 25. Wes case referred to medical examiner?

1 ☐ Yes 2 █ No Be Certification: To 27. Manner of Death 1 Naturel edicai 29a. Certifier (Check only one)

State

29b. Signature and title of certif

mo

29c. Licensa number 035103 29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6240 Montrose Road Rockville Md 20852 Vaccarc336 (1999) 32. Registrar's Signature

31. Date filed (Month, Day, Year) MAY 0 5 Registrar

Director

Funeral

by

Completed

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Examiner

Physician/Medical

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Physician

/Medical

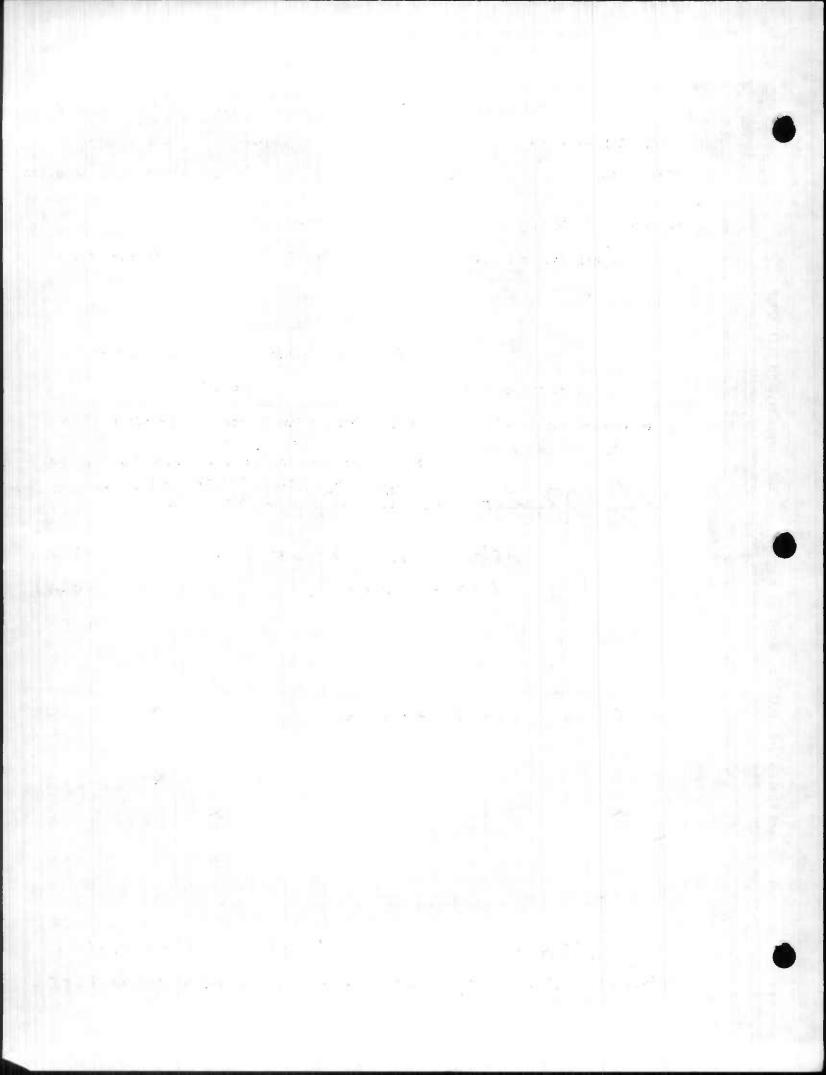
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Experiment must be notified at ence.

Physician

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

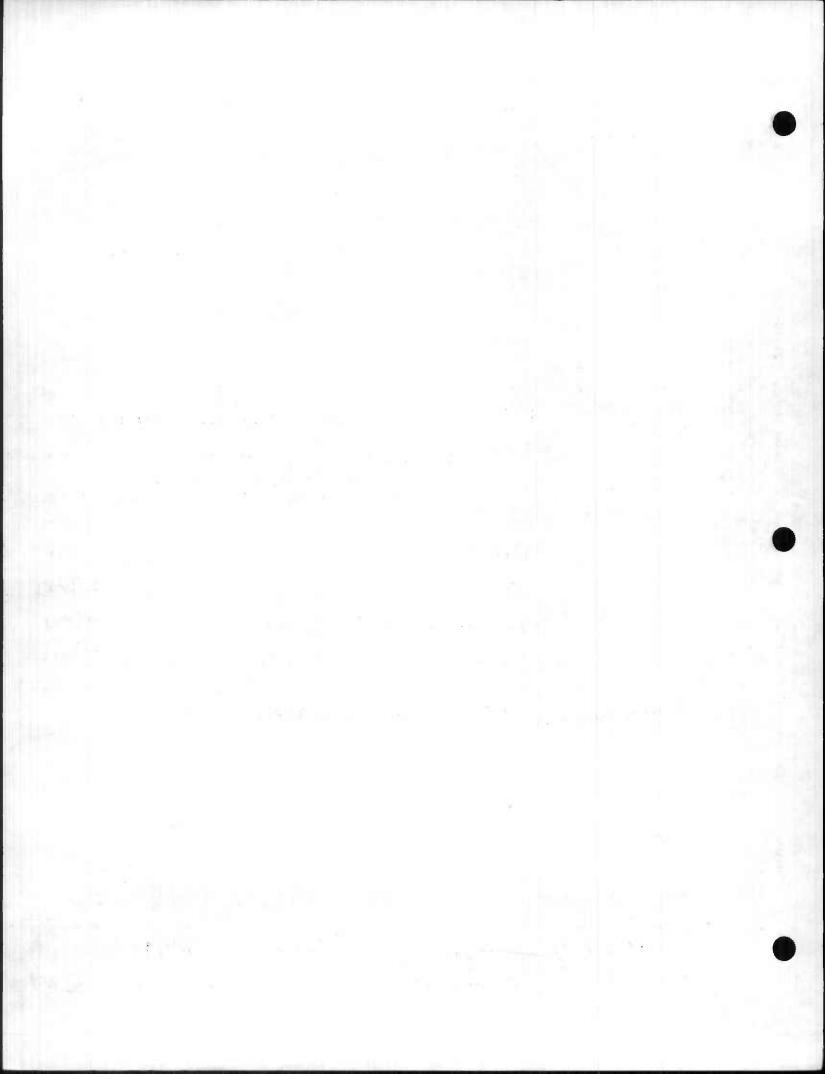
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1999 Chanelle Antonette Campbell May 4, 12:45 AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) April 29, 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Months Hours Yrs. 1999 Director none Maryland **Usual Residence of Decedent** e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or flama 23a or 28a-f ahow 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? frama 23a or 2 8914 Maine Avenue 20910 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: if Item 27 is marked other eny Injury or other treumatic event, pages. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rodney Anthony Campbell Nicoll Lee King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Rodney & Nicoll Campbell 8914 Maine Avenue, Silver Spring, Maryland 20910 parents 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Burial 2 Cremation 3 Removel from State Gate of Heaven 5-11-99 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 0 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervei Batween Onset end Death **Physician** tmmediate Cause (Finel disease or condition resulting in death) /Medical HYPOTENSION Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760, SUMONARY thet initieted events resulting in death) Last Due to (or as a consequence of) Rema 980 Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy 1 ☐ Yes > No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To After this 27. Manner of Death 28c. Injury et Work? 28d. Dascribe how injury occurred Division or Attending 5 Pending investigation 1 Naturat death. 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ne and eddress of person who completed ceuse of death (Item 23a) (Type, Print) P 1500 FOREST GLEN RD. SILVEN SPRINE MI) WYNEN mo HOLY CROW TELLEW 32. 31. Date filed (Month, Day, Year) gistrar's Signature State 071999

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Guy F. Campbell May 1 1999 9:00am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year I If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Dec. 24, 1917 9. Birthplace (State or Foreign Country) Pennsylvania 5. Sociel Security Number 7. Age (In yrs. lest birthday) Days Hours 1□M 2□ F 81 Yrs. 212-18-7682 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Bethesda Montgomery 10a. Street and Number 10f Zip Code 10g. Citizen of Whet Country? 4400 East West Highway 20014 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Technician Veterans Administratib 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Guy F. Campbell Elizabeth Stine 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig D. Campbell (Son) 4708 Rocky Mills Dr. Frederick, MD 21703 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Park Lawn Memorial Park 5-5-99 4 ☐ Donetion 5 ☐ Other (Specify) Rockville, MD Name and Address of Fecility Hines-Rinaldi 11800 New Hampshire 21. Signature of Funeral Service Licensi Avenue Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth CARTO PULMUMY ARACET Immediate Cause (Final disease or condition resulting in deeth) MULTER SYSAM ONGAN PATRICE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): SUPSTS Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? HUPATETES 1 Yee 2 No 3 Probably ∮€ Unknown 24a. Wes an autopsy performed? 24b. Were autopsy tindings evailable prior to completion of cause of death? 2/2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Inpatient 2 ER/Outpatient 3 DOA 1 Yes DNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 5 Pending investigation

Examiner AND CESO ŏ Division

Examiner

Physician

/Medical

Examiner

Funeral

Director

must be notified at

'natural', or itsme 72 hours after

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permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: If Item 27 is marked other any Injury or other traumatic avant

Physician

/Medical

death

Baltimore, Maryland 21215-0020

Director

Funeral

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Physician/Medical þ Completed Be 27. Menner of Death Certification: 1, Netural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

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within 24 ho 8

State Registrar

edical

29b. Signeture end title of continue

6 Could not be determined

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1 ☐ Yes 2 ☐ No

McCortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

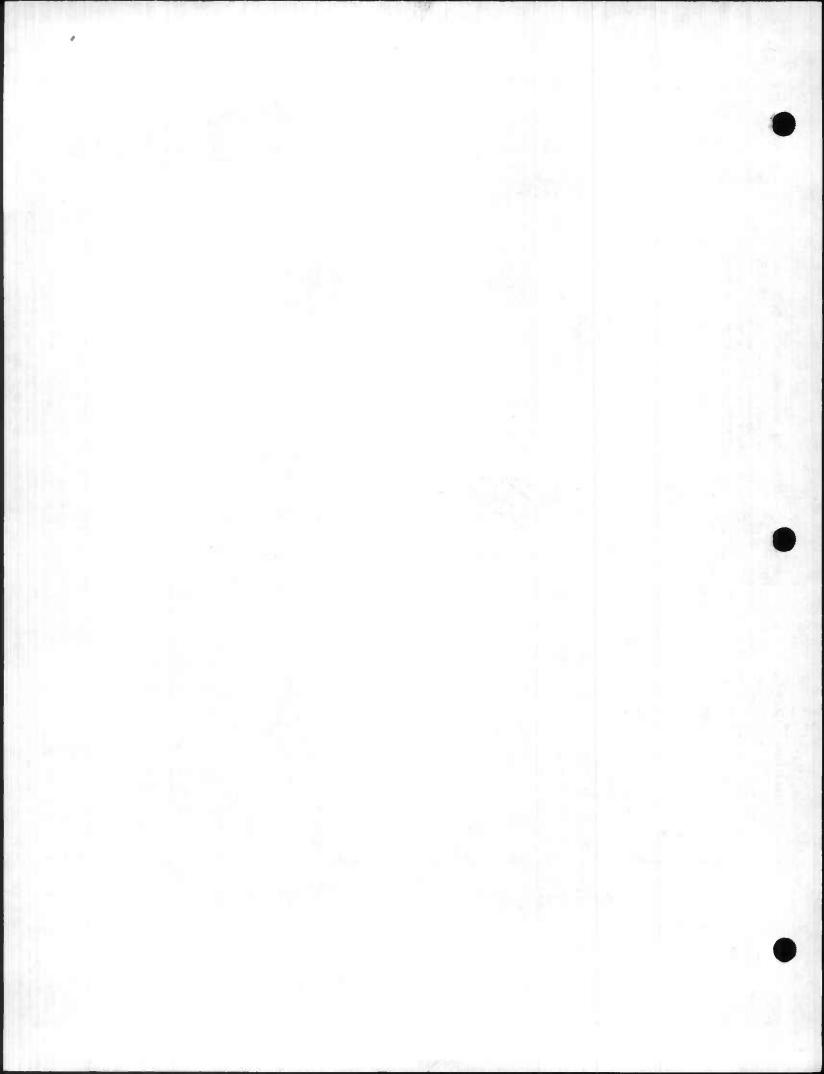
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31. Dete filed (Month, Dey, Year) 06 1999 MAY

32. Registrer's Signeture

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

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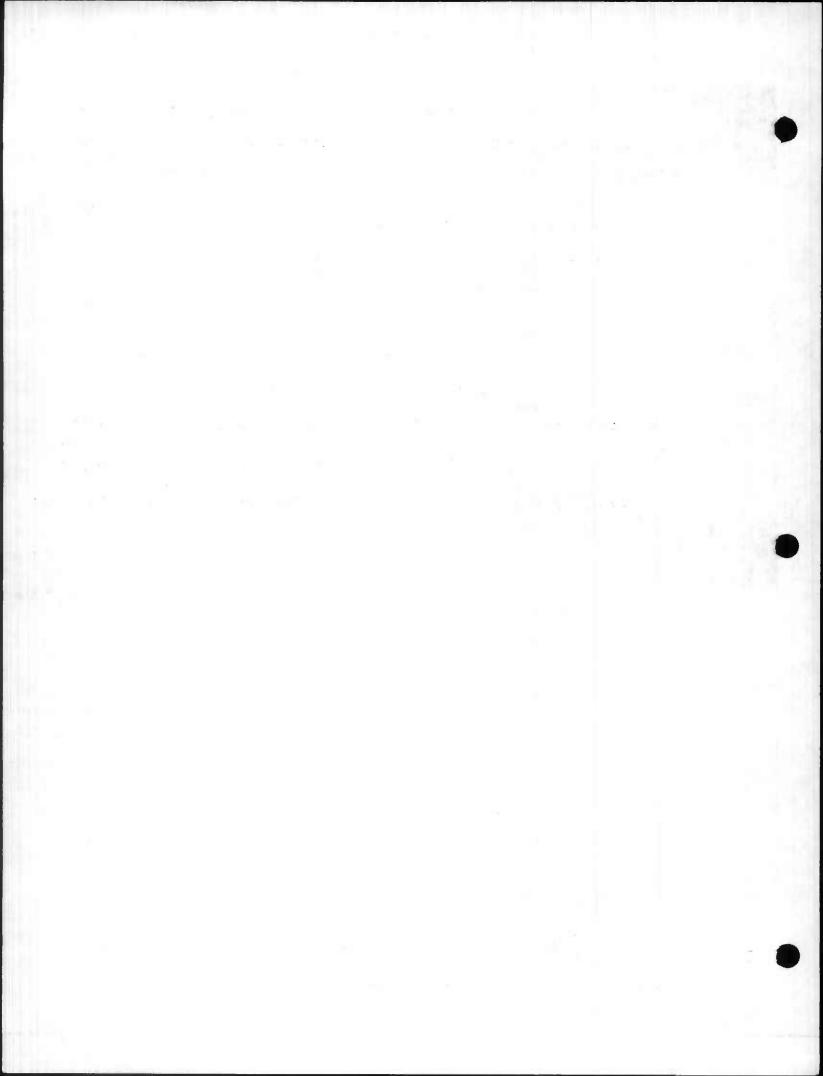
G. Sparks

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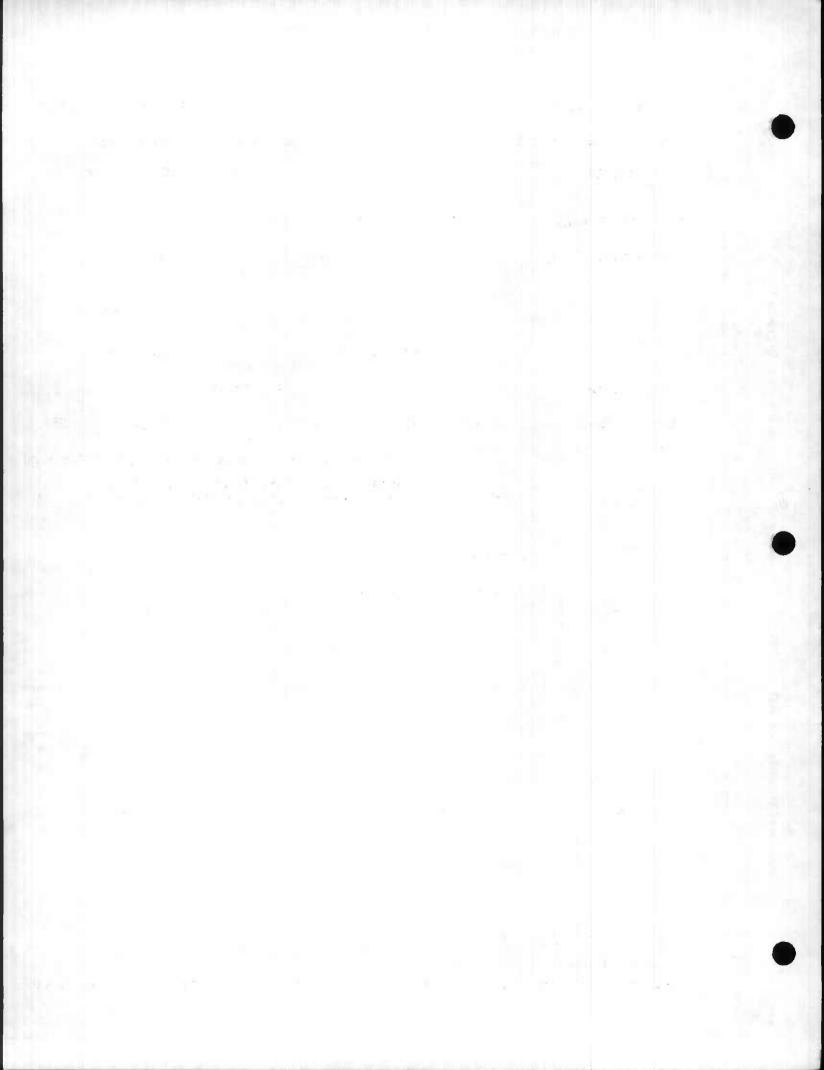
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State of Maryland / Department of Health and Mental Hygiene 99 | 5966

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aminer	4a Facility Nama (If not institution	on, giva st	reet and num	n <i>ber)</i>				4b. City, 10	wn, or Lo	ocation of Deat	tn 4c.	County	of Death					
	Holy Cross Hospital Silver S									ring	37							
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.									8. Date of Bi	dh	DILLE	omer 9 Birtho	lace (State or Fore				
al or			M 2 F	Yrs	Mon	ths Days	Hours	Min.	(Month, Di	ay, Year)		Coun	lace (Stata or Fore try)					
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	Usual Residence of Decedent																	
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5														1 ☐ Yas 2 ☑				
Director	Maryland Mont	gomer	У	S1.	lver S									1-1-1-1				
ire	10e. Street and Number					10f	. Zip Code				10g. Citiz	en of W	hat Coun	try?				
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Š	11. Marital Status	- '	Armed For	cas?	J,S. 1	if Yas,	specify Cub	oan, Mexican	, Puerto	ecify Yas or No Rican, etc.)	0-		k, White,					
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2	15. Decede	ot's Educa	otion		160 De	codent's	Heual Occur	nation			16b Kir		Asian					
10	(Specify only high	est grade	completed)		(G	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. KInd of Busi						311103371110	addity					
Completed	Elementary/Secondary (0-12)		Coilege (1-	-4or 5+)	- Inf	e. DO NO) i use retire	9d)										
6	12				Accountant						Acco	ount	ing					
	17. Father's Name (First, Middle	(ast)				Accountant Accounting 18. Mother's Name (First, Middla, Maiden Surname)												
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	Yuk Yam Chow		(9	son)	138	19 Ma	riann	a Driv	re :	Rockvil	le, Ma	ary1	and	20853				
	20a. Method of Disposition			20b.	Place of Di	sposition	(Name of or other pla			Date	20c. Lo	cation -	City or To	wn, State				
	1 ₺ Buriai 2 ☐ Cremation		movai from S	stata					i									
									y 5	5/5/99	9 Silver Spring, Maryla							
Depertment of Important: If I any injury or once.	21. Signalura of Funaral Sarvice Licensaa 22. Name and Address of Facility																	
Francis J. Collins Funeral Home, Inc.												nc.						
	500 University Blvd., W., Silver Spring, MD 2 23a. Part 1. Enter the disaasa, or complications that could the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, Approx												MD 20901					
	23a. Part 1. Eriter the disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.											Approximate						
	snock, or near failure. Lis	t only one	cause on ea	acri line.									1	Interval Between Onset and Death				
	Immediate Cause (Final		A	Mara		1 T. 6							1					
	disease or condition resulting in death)	a.	Acute	е Муоса				on	_				1					
bo				Due to	or as a con	sequence	e of):											
ne			Coror	nary A	rtory	0001	110010	n					1					
E		b.	COLO		or as a con			11										
Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury			Due to	or as a con	isequence	9 01).						1					
	cause. Enter Underlying												i					
edicai	I that initiated events	C.		Due to (or as a con	sequence	of):											
2	resulting in death) Last												i					
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an a		- u.											i					
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YS	Part II. Other significant condit	One Contr	ibuting to de	ain bui noi re	suning in th	e underly	ing cause gi	IVON IN PAIL I	•	23B. Dit	LODECCO	Dee Con	idibute to	the cause of dea				
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Q										1 🗆	Yes 25	₹ No	10	Yes 2□ No				
	25. Was cese refarred to medic	el						26. Place	of Deal	th (Check only	one)							
De	examinar?		spital:				Ot	ther:										
0	1 ☐ Yes 2 🔀 No		1 🗆 Ir		J ER/Outpa	atient 3	I DOM	4 LINU	rsing Ho	ome 5 Res	sidence 6	Othe	er (Specifi	y)				
	27. Manner of Death		28a. Date o	of Injury h, Day Year)	28b. Tim		28c. Inju	iry at		28d. Describe	how Injury	y occurr	ed					
5	1 Natural 5 Pand	ng igation	(INION)	i, Day Toar)	fnju	M		Yes 2	No									
Certification:	2 Accident Inves										10							
=		mined	28e. Place buildin	of Injury - At ng, etc. (Spec	home, tarm.	, street, ta	ictory, office	1			(Street and		er or mura	Il Route Number,				
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Σ	29b. Signature and title of certifi	ar /					29c. Licen	sa number			29d Date	e signed	t (Month,	Day, Year)				
	1/	1	10	/	11		IINX	1/1	71	11	The second of	-1	-/	Control of the contro				
	thei	re	1	- /,,	una	m	17)	1//	4	1/		5/	5/0	19				
	30. Name and address of person	who so	nloted cause	a of doub In	m 22a) (T	no Drine	11	1/		()		1	1	1				
	So. Maine and address of person	WILL COLL	ipieted causi									*						
	Hector K. Coli	lison	, M.D.	. 840	Cole	esvil	le Ro	ad #31	10	Silver	Sprin	ng.M	lary1	and 2091				
te	31. Date filed (Month, Day, Year		32. Re	gistrar's Sign	nature							0,	,					
			1	eneva	. 1		par	1.										
rar	MAY 04	1999	A	The same		. 16	work	1										



Physician Examiner physicien and s the burial-transit The law requires that the death certificate be executed

ettanding for use as

the signed by the

should

has 9 2 is certificata has director, page 2

al or Attanding Physician: The safter deeth.

I Director: After this certificated in by the funeral director, pa

in 24 hour. the Funeral Dire Hospital

To the To the To the

10

"natural", or items 23a or 28a-f show idical Examiner must be notified at

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital

filed within Hygiene.

Pages 1 and 2 should be

Mental

is marked

	examiner?	2XN	lo	
27.	Manner of	Death	E □ Bondin	_

31. Date filed (Month, Day, Yaar) MAY 0 6 1999

investigation

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifiar (Check only one)

2 Accident 3 Suicide

4 Homleide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of cart

033942

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) PROMOD

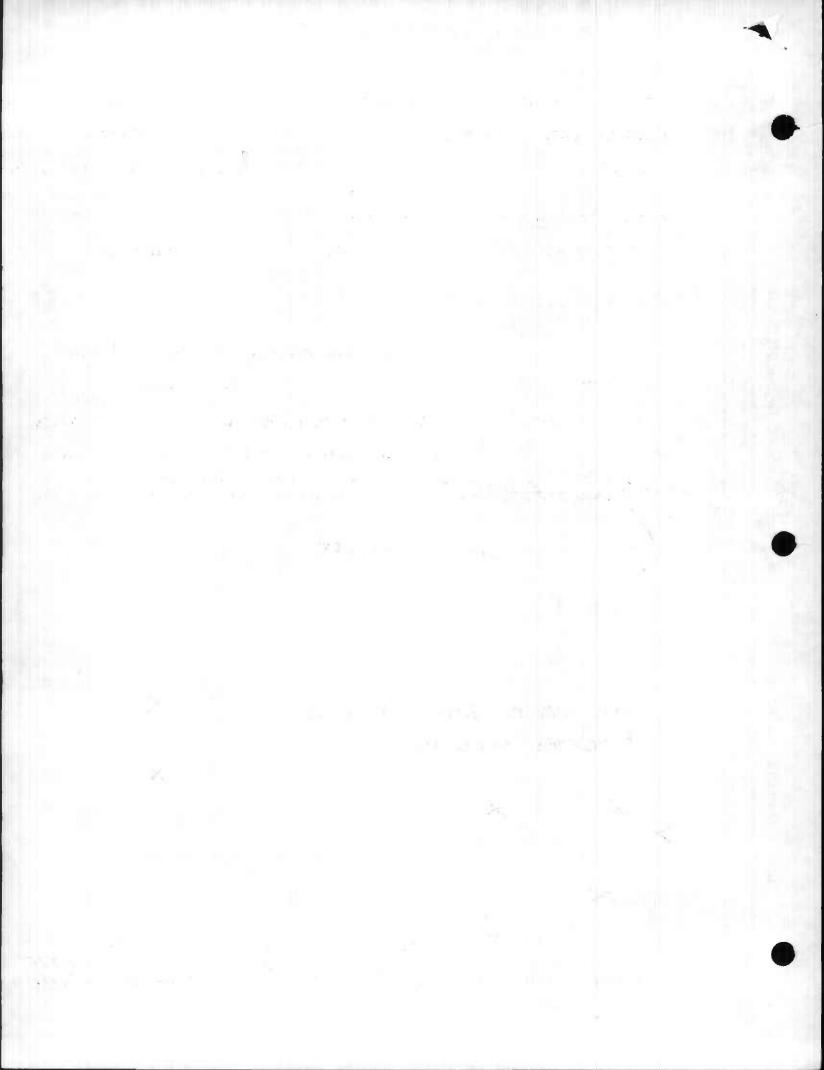
DUGGHL, MD. 7253 B HANOVER PKWY, GREENBELT, MA

State Registrar

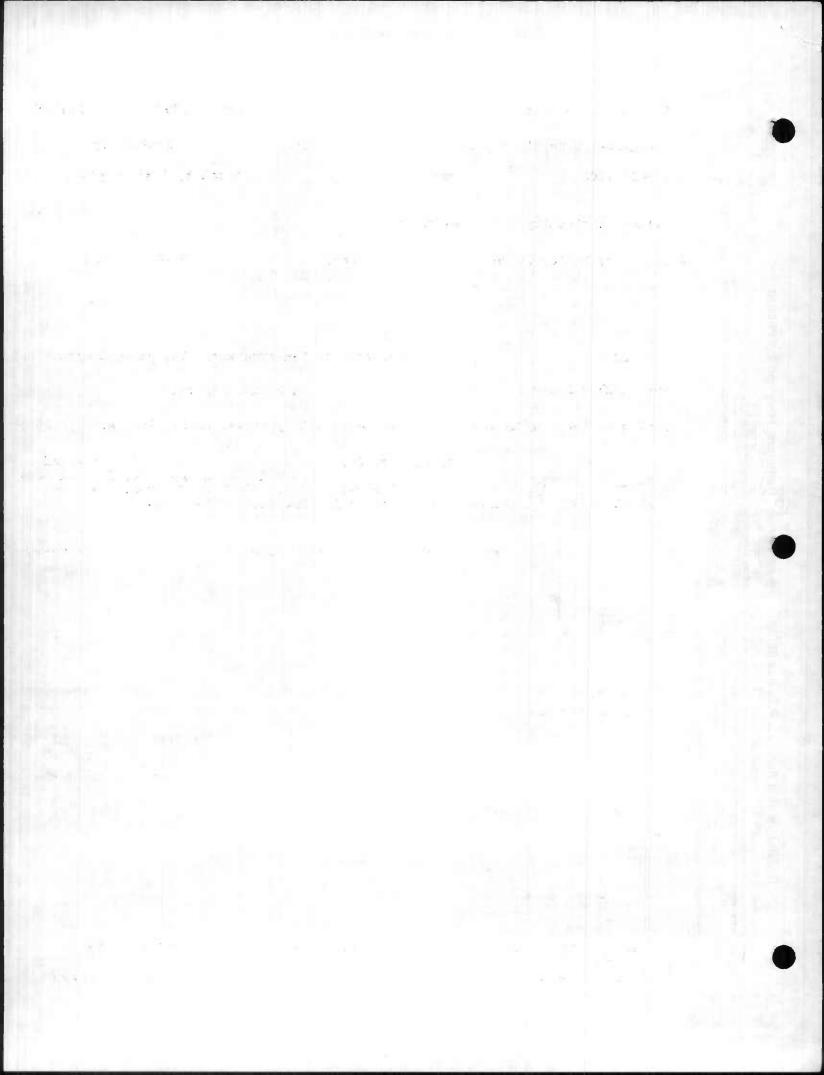
edical

32. Pegistrar's Signature

MD



	5/99, BMW, Montg. Co 1. Decedent's Name (First, Middle, Last) Certificate of Death							2. Date of D	Reg. No. 2. Date of Death 3. Time			
an								Month	onth Day Year			
al er		S S. Cochr							2, 1999 2:10AM			
r												
		Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yr				If Under 1			Montg		y lace (Stete or Foreign etry)	
	219-34	-7202	□ M 2 X F 61 61 Yrs. M			Months [Days Hours N	March	6, 1938 Maryla		land	
	Usual Residenca	of Decedent		100 CH	. Tour or Loss	ation				1	0d. Inside City Limits	
			10c. City, Town or Location								1 ☐ Yes 2 🕅 No	
	Maryland Montgomery Rockville 10e. Street and Number 10f. Zig						and a	10g. Citizen of Whet Country?				
	4821 Che	rry Valley				20853 Vas Decedent of Hispanic Orlgin? (Specify Yes 1 Yes, specify Cuben, Mexican, Puerto Rican, et			United States or No- 14. Race - American Indien,			
	1 Never Mo	erried 2 Merried	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:			If Yes, specify Cuben, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:			Specify Specify	ock, White, etc. Mhite		
	10-	15. Decedent's Ed	ucation 16a. Decedent			nt's Usual Occupation			16b. Kind of Business/Industry			
		condary (0-12)	Coilege (1-4or 5+) (Give life. I			kind of work done during most of working DONOT use retired)						
	1	2				strat	ive Super		Telephone Company			
		e (First, Middle, Lest)							e (First, Middle, Maiden Surneme)			
		rthur Shan			105 11 2	A alabara a M			ine Berryman Gural Route Number, City or Town, Stele, Zip Code)			
		Name/Relationship (7										
	20a. Method of D			20b. P	lace of Disposi	ition (Neme	of	Date	20c. Location -		yland 2085 own, State	
	1 🗆 Burial	2 Cremetion 3 🗆		0	emetery, crem	etory or othe	or placa) May					
		5 ☐ Other (Specify			tgomery Crematorium, 22. Name and Address of Facility R				sda, Maryland			
	Rockville, Inc. 300 Wes Rockville, Maryland 200						300 West	st Montgomery Avenue 850-2805				
	23a. Part1. Ente shock, or h	r the disease, or comp eart failure. Ltst only o	plicetions that caused one cause on each ii	the death ne.	n. Do not enter	r the mode	of dying, such es car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Immediate Ceus	o (Eina)	0.000	47-	0 11		****			1		
	disease or cond resulting in deat	tion	REFRACTORY SMOCK with Sopsis								41 HOURS	
			Due to (or es a consequence of):									
	Convention to line	anadistana C	b. Due to (or as a consequenca of);									
	Sequentially list if any, leading to cause. Enter Ur Ceuse (Disease	immediate	בעם זו נעו מם מ בייווסקעיסויטי טון.									
á	Ceuse (Disease	nts	c Due to (or as a consequenca of):									
1	I that initiated eve	n) Last										
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	I that initiated eve	n) Last	d							i		
	that initiated eve resulting in death	nificant conditions co		ut not resi	ulting in the und	dertying cau	se given in Part I.	23b. Die	d tobacco use co	ntribute to	o the causa of death?	
· · · · · · · · · · · · · · · · · · ·	resulting in death		entributing to death b	ut not resi	ulting in the und	dertying cau	se given in Part I.				o the cause of death?	
	resulting in death	nificant conditions co	entributing to death b	ut not resi	ulting in the und	dertying cau	se given in Part I.	10	Yss 2E No	3 Prol	bably 4 Unknown	
	resulting in death	nificant conditions co	entributing to death b	ut not resi	ulting in the und	dertying cau	se given in Part I.	1 [24a. Wa		3 Prol	babty 4 Unknown	
	resulting in death	nificant conditions co	entributing to death b	ut not resu	ulting in the und	dertying cau	se given in Part I.	24a. Wa	Yss 2 No	3 Prol	ere eutopsy findings allable prior to mpletion of cause death?	
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	Part II. Other sig	nificant conditions co	Hospital: 1 Inpatie	ent 2	ER/Outpatient	3□ DOA	26. Piace of Other: 4 \(\text{Nursin} \)	24a. Wa per 1 Death (Check only ing Home 5 Re	yss 2 PNo ssan autopsy formed? Yes 2 PNo yone)	3 Prol	ere eutopsy findings allable prior to mpletion of cause death?	
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	Part II. Other sig D. 1 1/2 25. Was case re exeminer? 1 Yes 2 27. Menner of De 1 Neturet 2 Acciden 3 Suicide 4 Homicid 29a. Certifier (Check only one) 29b. Signature a	lerred to medical No Permit of continues to the permit of the permit o	Hospital: 1 Inpatie 28a. Date of Inju (Month, De) 28e. Place of Inju building, etc. valclan: To the best of and manner sta	ont 2 Ury y Year) ury - At ho. (Specify the control of my known of examinal of the control of t	ER/Outpatient 28b. Time of Injury ome, ferm, stre	3 DOA 286 M et, factory, (cocurred at astigation, in	26. Place of Other: 4 Nursin Injury et Work? 1 Yes 2 No offica	24a. Wa per 1 Death (Check only ng Home 5 Re 28d. Describe 28f. Location City or T	Street and Numbown, Stele) e ceuse(s) and me a, date and place,	3 Prol 24b. Www.co. of 1 [er (Specified Specified Speci	bably 4 Unknown fere eutopsy findings allable prior to impletion of cause death? Yes 22 No N) If Route Number, stated. o the cause(s) Day, Year)	
medical cel illication. To be completed by his sicial medical Examined	Part II. Other sig Part I	lerred to medical How Modern	Hospital: 1 Inpatie 28a. Date of Inju (Month, De) 28e. Place of Inju building, etc. 28d. To the best	ont 2⊡ ry y Year) ury - At he c. (Specify of my knod examinal ated.	ER/Outpatient 28b. Time of Injury ome, ferm, stre y) wledge, death tion and/or inve	3 DOA 28c M et, factory, coccurred at sstigation, in	26. Place of Other: 4 Nursin Injury et Work? 1 Yes 2 No offica the time, date and p my opinion, death of	24a. Wa per 1 Death (Check only ng Home 5 Re 28d. Describe 28f. Location City or T	yes 2 No s an autopsy formed? Yes 2 No yone) sidence 6 Oth e how injury occur. (Street end Numbown, Stete) e ceuse(s) end me e, date and place, 29d. Date signe	3 Prol 24b. Www.co. of 1 [er (Specified Specified Speci	bably 4 Unknown fere eutopsy findings allable prior to impletion of cause death? Yes 22 No N) If Route Number, stated. o the cause(s) Day, Year)	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month Physician May 4, Albert S. Coleman 10:30 pm 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda If Under 24 Hrs. 8. [Suburban Hospital Montgomery If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1⊠M 2□ F Months Days Hours Director 80 577-12-7484 July 1, 1918 Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health end Mentel Hygiena. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show early follury or other traumatic avent, the Medical Examples must be notified at each. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5110 Hampden Lane 20814 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Officer 4 C.I.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Thomas C. Coleman Leola Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas S. Coleman/ Son 78 Winsor Place Glen Ridge, New Jersey 07028 20b. Place of Disposition (Name of cemetery, cremstory or other place) May 7 Potomac United Methodist Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Remove! from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac, Maryland 21. Signature of Fuheral Service Licenses Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. 1557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. — int only one cause on each line. Approximate Interval Between Onset and Death **Physician** Chronic Obstactive Pulmonary Disease /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the buriel Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown malation P 24b. Wera autopsy findings evailable prior to 24a. Was an autopsy Completed completion of cause of death? 1 Yes 2 2Ne 1 ☐ Yes 2 ☐ No Division of Vitai funeral director, 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Hapatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | JNo this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. trijury at Work? Certification: After 5 Pending 1 EMatural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 044157 MAY 5, 1999 + 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 808 vels mill Road, Rockille, maryland 20851 IRA BERGER M.O.

State

Registrar

31. Date filed (Month, Day, Year)

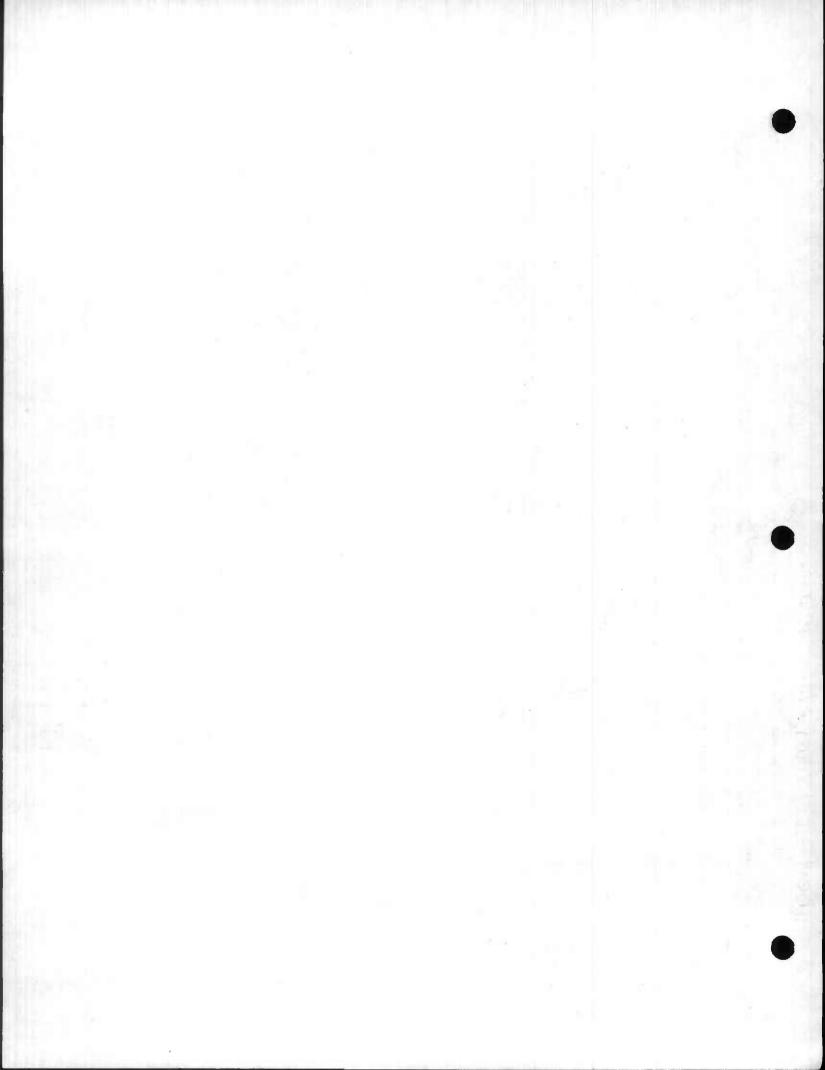
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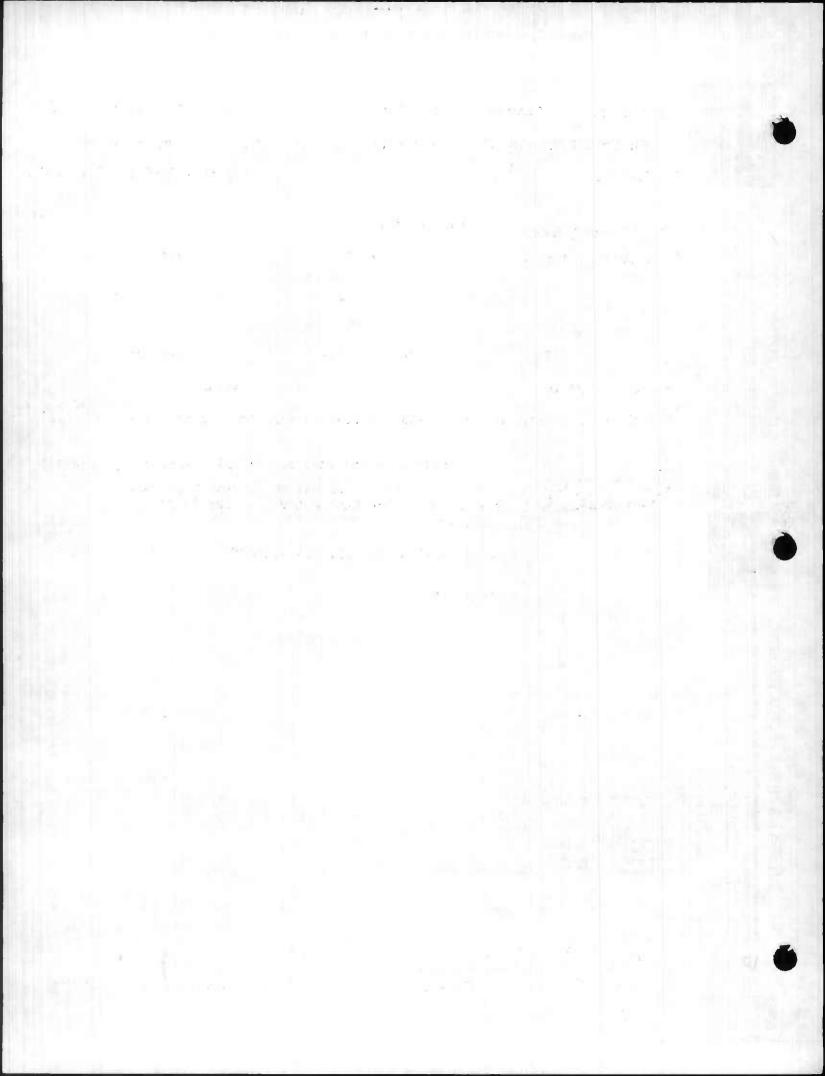
32. Régistrar's Signature

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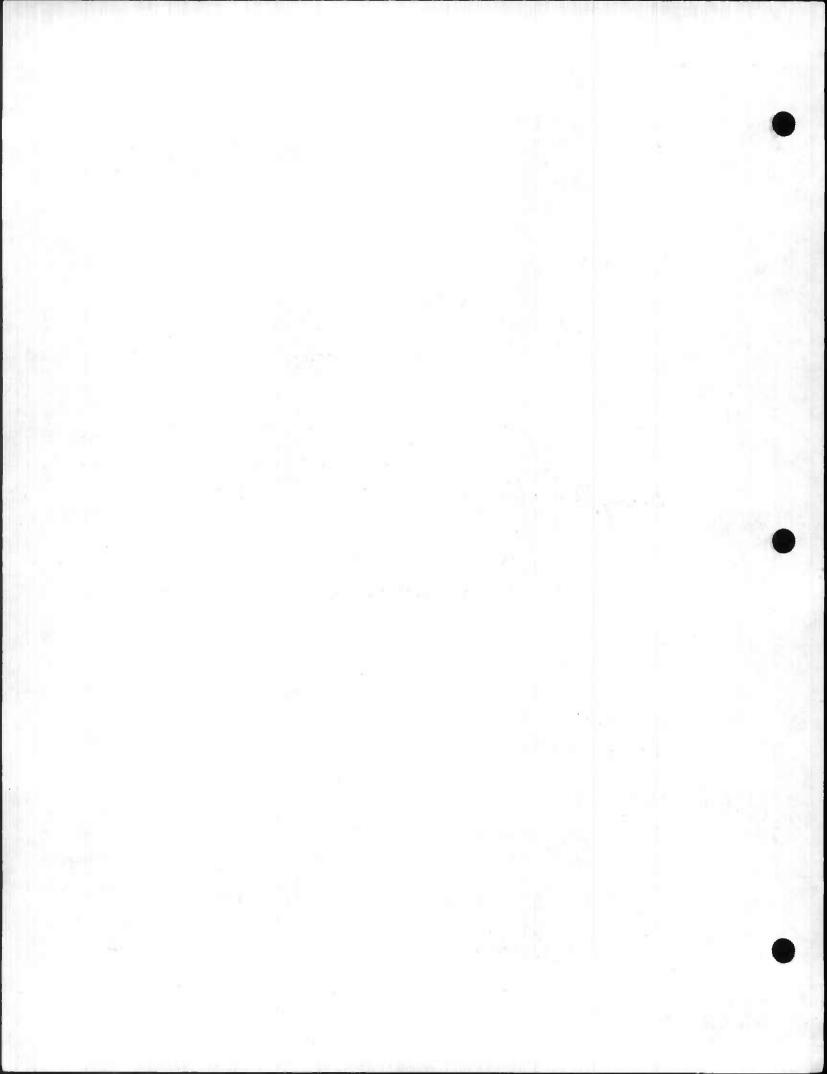


State of Maryland / Department of Health and Mental Hygiene

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or 28	10e. Street and	Number	nety			10f. Zip (Code			10g. Cltizen of	What Cour	ntry?
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al, or items 23e or 23e-f show Exeminer must be notified at by Funeral Director		arried 2 Married	12. Wes Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Detes:	?		Vas Decede Yes, speci ☐ Yes 2			Specify Yes or N to Rican, etc.)	Ble	ce - Americack, White,	etc.
d other than "natural", or svent, the Medical Exemi Be Completed by F		15. Decedent's E pecify only highest g	rade completed)		16a. Deced (Give I life. D	ent's Usual kind of work OO NOT use	k done di	iring most of wo	rking	16b. Kind of E	Business/In	dustry
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To Be	Bernar	d L. Perr	y					Annie H	1. Bisho	p		
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other of	20e. Method of I				ece of Dispos metery, crem	sition (Nem	ne of ther place)	Dete	20c. Location	- City or To	own, State
T. 70		2 ☐ Cremation 3 in 5 ☐ Other (Spec	Removel from Stete cify)	Plea	sant v	alley	1 Cen	neteru	5/6/99	Annand	ale,	Virginia
Important: If eny Injury or pace.	2 Signature of	Fuperal Service Pop	ognee C	00	Ro	Name and	J. N	of Fecility Murphy F	uneral	Home, In		
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sit			b. PNEU	IMONIA								
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ched ched	Part II. Other elg	gnificant conditions	contributing to death	but not resul	lting in the un	iderlying ce	euse give	n in Part I.				o the ceuee of d
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should should									24a. Wa	s en eutopsy formed?	av cc	ere autopsy findi reilable prior to empletion of caus death?
page 2 s									10	Yes 20 No	11	Yes 2 No
rector, pag		eferred to medical						26. Place of De	eth (Check only	one)		
	examiner?	No	Hospital:	ient 2 E	ER/Outpatien	3 DO	A Othe	f: 4 Nursing	Home 5 Res	sidence 6 🗆 O	ther (Speci	ty)
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al Director: After t led in by the funers Certification:	1 Neturei 2 Accider 3 Suicide 4 Homick	6 Could not	be 28e. Place of le	njury - At hor	me, farm, stre	M eet, fectory	1 🗆 Y	es 2 No		(Street end Num	nber or Run	el Route Number
er in				tc. (Specify,								
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To the Funeral completely filled Medical C	1	SIN A !	Ball mo o completed ceuse of devick				23		theist	2/4	177	



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cian									Month	Day	Year	
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er	4a Facility Name			umber)						4c. County	of Death	
		oss Hos	pital 6.Sex	7 4 //	In ad birth day it	If Under 1 Ye		r Spri	ng Data of Birth	Mont		
	5. Social Security 578+03-50 384-05-6	1180	1 M 2 □ F	7. Age (In yrs. 80)	Yrs.	Months Da		Min.	Month, Day	, Year)		place (State or For ntry) ington,
	Usual Residence of								7111	3 1010	Waoii	ingcon
	10a. State	10b. County		10c. City	y, Town or Lo	cation					1	10d. Inside City Lir
DIFECTOR	Maryland	Monts	gomery		Wheato	n						1 ☐ Yas 2 💢
5	10e. Street and No		,			10f. Zip Cod	9		1	0g. Citizen of V	Vhat Cour	ntry?
	12012	Valleyw	ood Drive	0		209	02		18	United	Stat	- 00
	11. Marital Status	valleyw	12. Was Dec	cedent Ever in U,	,S. 13.	Was Decedent	of Hispanic Orig	gin? (Specify	Yes or No-	14. Rac	e - Americ	can Indian,
	1 Never Man	mied 2 Marrie		2 No Siva World		If Yes, specify C 1 ☐ Yes 2 🖔 I		, Puento Mica	in, etc.)	Specify	k, Whita,	etc.
	3 🖾 Widowed	4 Divorced	Year or I	Dates: War						Specify		ite
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	Elementary/Sec			(1-4or 5+)	lifa.	DO NOT use re	ired)			Unite	ed St	tates
			3	HI LA	Elect	rical F				Gove		nt
	17. Father's Name	(First, Middle, L	ast)				18. Mothe	rs Name (Fi	rst, Middle, i	Maiden Sumam	na)	
	John C	Courtney						Sally	Harvey	7		
	19a. Informant's N	Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Str	eet and Numbe	or or Rural Re	oute Numbe	r, City or Town,	State, Zip	Code)
	Michael		tney / se	on	19804	Beatri	z Aveni	ie, Po				
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		5 Other (Sp		1 Otalo		n Natio	-			Arlingto	on. I	/irginia
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-	23a. Part1. Enter shock, or he	the/disease, or o	complications that	caused the death							Lylan	Approximate
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Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other signi Part II. Other signi Pneumo Acute 25. Was case referencements 1 Yes 20 27. Manner of Dea 1 Kinatural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and	ifficant condition ifficant condition coccal Renal F red to medical No ath 5 Pending investig 6 Could medical 1 Certifying 2 Medical E d title of certifier Lices of person w	c. d. se contributing to describe the contributing to describe at lure Hospital: 1 K 28a. Data (Monator) at long the best of the companion of the land management of the companion of the land management of the companion of the land management of the la	Due to (or Due to	ER/Outpatier 28b. Time o Injury wedge, deattion and/or in	nt 3 DOA DOA Meet, factory, offine recurred at the vestigation, in n	26. Place Other: 4 Nu njury at Nork? Yes 2 ce e tima, date anny opinion, dea	of Death (C resing Home 28d No 28f. d place, and th occurred a	1 Y 24a. Was a perfor 1 Y theck only or 5 Resid. Describe h Location (S City or Tow due to the cut the time, cut	in autopsymed? es 2 No es 2 No es 2 No es 2 No es 6 Oth ow injury occur treet and Numb n, State) ause(s) and ma late and place, e9d. Data signe May 3,	24b. Washington of 11 anner or Ruranner as a and due to differ the second of the secon	o the cause of debably 4 Uniter autopsy findirallable prior to mapletion of caus death? Yas 2 No Yas 2 No Ty)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:40 AM MABEL IRENE ROSE CRAWFORD 4b. City, Town, or Location of Death 1999 4c. County of Death 4a Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Nov. 16 1 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days Hours 1 M 2 F 213-38-3409 89 Yrs. 1909 West Virginia Nov. Usual Residence of Decedent 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 14428 20853 Brad Drive United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Albert Lewis Rose Mary Margaret Marple 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14428 Brad Drive, Rockville, Maryland Jean C. Eister/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1.⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/7/99 Flatwoods Cemetery Flatwoods, W. Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lie Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstructive Ling diverse Due to (or as a consequence ot): Preumonia Due to (or as a consequenca ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Organic brain Cyndrine 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tyes 2 No 1 Ves 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

physician and the bunal-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ettending ph signed by the e After this certificate has funeral director, page 2 or Attending Physician: death. s after de. 24 hours after Funeral Dire letely filled in b

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with it.
Department of Health and Mentel Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, tin Medical Examiner must be not once.

Physician

/Medical

Examiner

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

To the Hosp within 24 ho To the Fune completely fi 30

3 Sulcide 4 Homicide 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifie

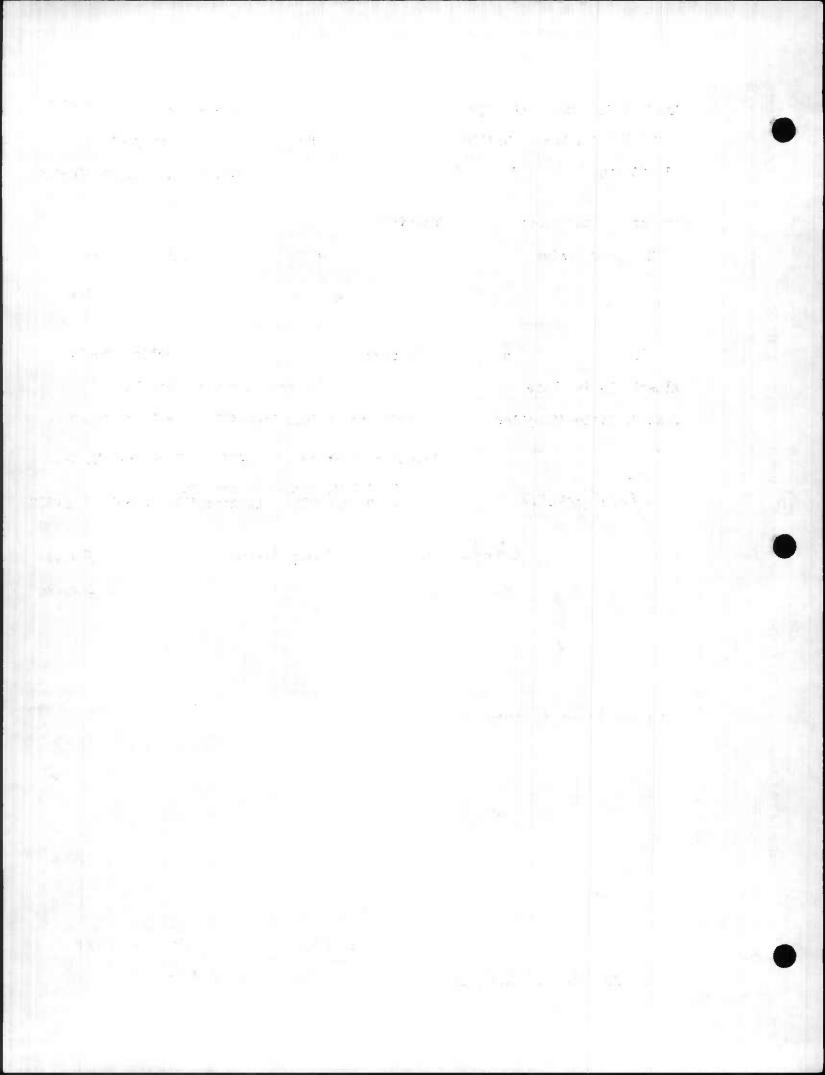
29c. License number D18726

29d. Date signed (Month, Day, Year)

in who completed cause of death (Item 23a) (Type, Print) PRINCE Philip DR

DLNEY

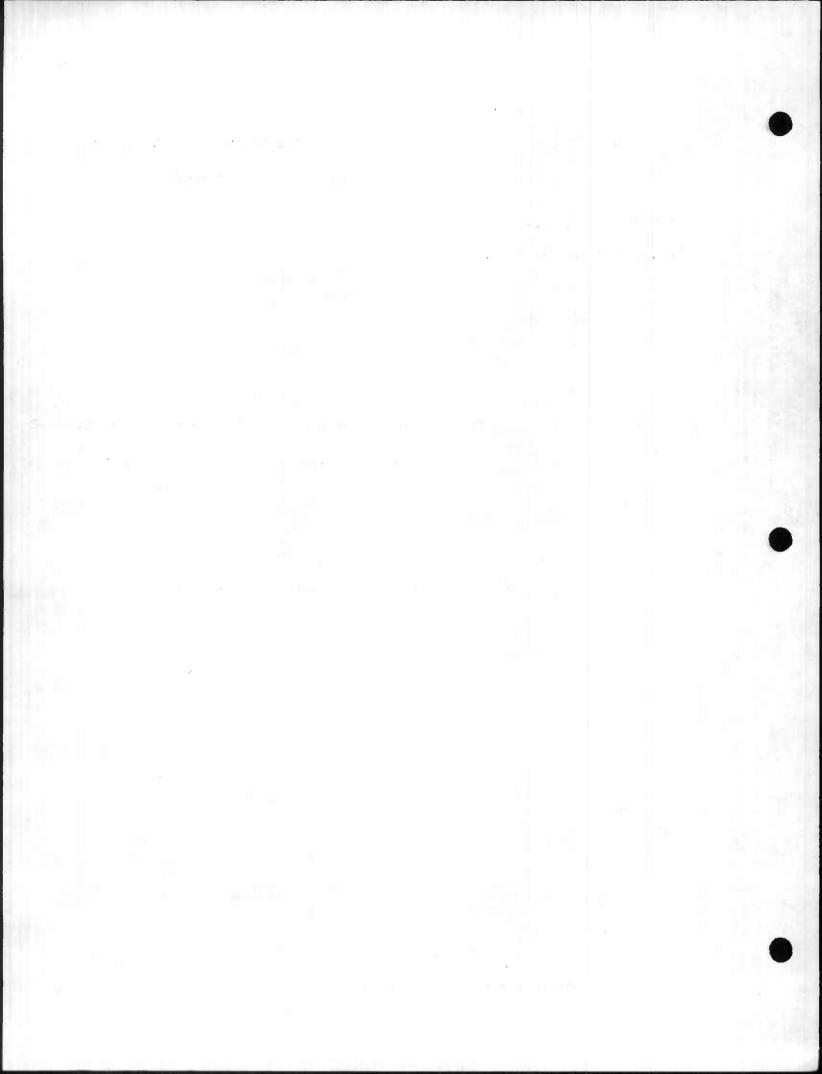
State Registrar 31. Date filed (Month, Day, Year) MAY 05 1999 32. Pegistrer's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Yaar **Physician** May 2, 1999 6:20 PM John R /Medical Crump 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner 14800 Penfield Circle #211 Silver Spring Montgomery If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax **Funeral** Days Hours 1 M 2 □ F Vrs Director 577-28-7365 76 June 10, 1922 Washington, D. C. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14800 Penfield Circle #211 20906 Funeral USA death 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar In U.S. Armed Forcas? 14. Race - Amarican Indian, 11 Marital Status Black, Whita, atc. hours after X Yas 2 1 ☐ Nevar Married 2 X Married 2 No natural', or Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🛣 No Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry filed within Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) F.B.I. Investigator 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Be permit. Peges 1 and 2 should be: Department of Heelth end Mental Important: If Item 27 Ia marked or 2 Crump Samuel O'Neill Anna 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Silver Spring, Maryland 20c. Location - City or Town, Stata Florence M. Crump (wife) 14800 Penfield Circle #211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 1 XBurial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 5/6/99 Silver Spring, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest,

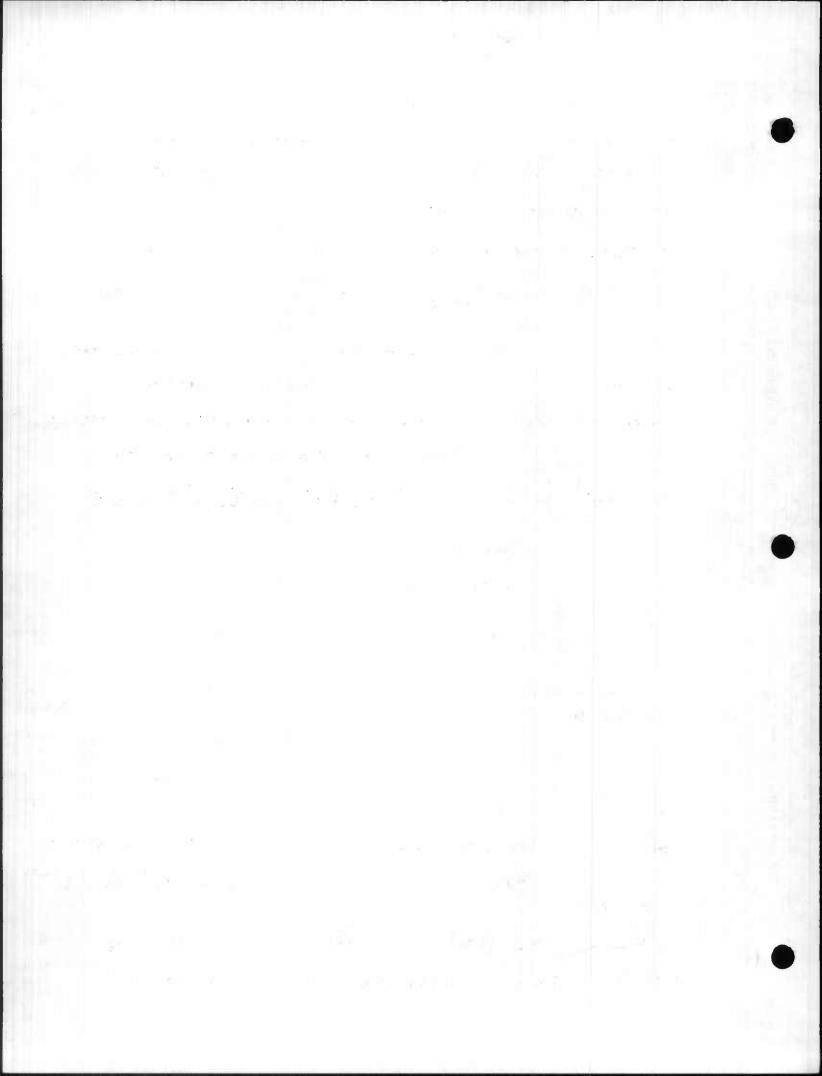
Approximate Approximata Interval Batween Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting In death) Examiner Examiner ta QIN en that the death certificate be executed physicien and is the bunkl-trans Sequentially fist conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequance of) P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown signed t Records, by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s has 22 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director, I Be 25. Was casa refarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 1 Yas 2 No Other: 4□ Nursing Homa 5☑ Rasidence 6 □ Othar (Specify) Medicai Certification: To 2 ER/Outpatient 3 DOA 27. Mapnar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined 3 Sulcida 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of axaministion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and magner stated. 29a. Certifian To the Hosp within 24 hou To the Fune completely fil 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 204 30. Nama and addrass of person who complated ausa of death (Itam 23a) (Type, Print) Howard S. Goldstein, M.D. 4701 Randolph Road #105 Rockville, Marvland 20852 31. Data filed (Month, Day, Year) 32. Regisfrar's Signatura State MAY 04 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 5 7 4

			Certi	ficate o	f Death		Reg. No.		
	1. Decedent's Name (First, Middle, Las	ot)				2. Data of Dea		Year	3. Time of Death
Physician /Medical	SIDNEY	S. (CUMMINS			MAY	2, 199		10:30AM
• Examiner	4a Facility Nama (If not institution, giva	street and number)			4b. City, Town, o	Location of Death	4c. County of	Death	
(4)	Holy Cross Hospit	al			Silver S	pring	Montgo	mery	
Funeral Director	5. Social Security Number 6. Sec. 562-03-0050	9x ☑ M 2□ F 7. Age (In yrs.		If Undar 1 Ye Wonths Day	ar If Undar 24 Hr	8. Data of Birt (Month, De Oct. 5,	y, Year) 1912 N	9. Birthplac Country I ew Y c	ca (State or Foreig y) Ork
2	Usual Residence of Decedent	10-0	7-11-1-1-1					140	4 1 - 14 - 65 - 15 - 1
arf show	MD 106. County Montgome		y, Town or Local Liver Sp					100	d. Inside City Limit 1 ☐ Yes 2 ☒ N
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by by	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Evar in U Armed Forcas? 1 Tayes 2 □ No If Yes, Give Year or Dates: WW I	1		f Hispanic Origin? (uban, Mexican, Pue lo Specify:	Specify Yes or No- irto Rican, etc.)	Black,	- Amaricar , White, etc White	c.
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within ene.	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			na during most of w ired)		U.S. G		
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Mental H Mental H mrhed oth atic even	17. Father's Name (First, Middle, Last) Max Cummins				Catheri	ame <i>(First, Middl</i> e, Lne Blu	<i>Maidan Sum</i> ema) estone	,	
2 should be and Mentals is manked summatic a	19a. Informent's Neme/Relationship (7	ype, Print)	19b. Melling	Address (Stre	et end Number or i	Rurel Route Number	er, City or Town, S	tete, Zip C	Code)
27 19 2	Gladys Cummins-Sp	ouse	1131 U	nivers	ity Blvd	West #50	4 Silver	Spri	ing, MBo
Semili. Pages 1 and 2 Department of Health a mportant: If them 27 is ning injury or other tra	20a. Method of Disposition 1 ⊠ Buriat 2 □ Cremation 4 □ Donation 5 □ Other (Specify)	Removal from State	Placa of Dispositi cemetery, creme	ion (Neme of tory or other p		Date 5/4/99	20c. Location - Co Olney, M	City or Tow	
permit. Pag Department Important: I any injury o	21. Signature of Fundani Service Licens				dress of Facility -Goldberg	Memoria	1 Chapel:	s, Ir	ıc
	a. Part1. Enter the disease, or comp shock, or heart failure. List only o	Chick.	117	0 Rock	ville Pil	e Rockvi	11e, MD	20852	
rificate be executed represented on the buriel-transit as the buriel-transit Medical Examiner	disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or Injury	b. Revibe FA	or as e conseque or as a conseque					1	
	thet initialed events resulting in deeth) Last	Due to (c	r as e conseque	nce of):				1	
let the daath ce d by the attendi letached for use Physician/I	Pert II. Other eignificant conditions co	ontributing to death but not res	ulting in the unde	erlying cause	given In Part I.	23b. Dld	lobacco use cont	ribute to t	the cause of deat
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aw requii							an autopsy rmed?	avall	e autopsy findings lable prior to spletion of cause eath?
The law ate has by page 2 s						10	ras 2200	10	Yas 2 No
dclan: The certificate rector, pag	25. Was case referred to medical				26. Place of D	eeth (Check only o	one)		
Physician: this certific ral director.	examiner?	Hospitel: Inpatient 2□	ER/Outpatient	3□ DOA	Other: 4 Nursing	Home 5 ☐ Resid	dence 6 Othar	(Specify)	
ding Ph Aftar th funeral	27. Mannar of Death 1 □ Netural 5 □ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Ir	njury at Vork?		now Injury occurre		1
Attending In death. octor: After by the fune.	Accident Investigation	April 23, 1999	2200		☐ Yes 2 XNo	TRIPPED	AT HOME &	- CAME	D ON HIP
or Att	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of tnjury - At h building, etc. (Specil	ome, ferm, streety)	t, factory, offic	> 8	City or To	Street and Number vm, Stete) 1131 SRYK-	WILE	PULL ALUR
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the H in 24 the F spiete	one)	and manner stated.	TOTAL BELLEVIEL IN 1985						
To the To the comple	29b. Signature and title of certifier	and (may)		-	anse number		29d. Date signed		ay, Year)
10	1	wo (our)		Oli	5236		MAY 3, 1	1999	
t -	30. Name and address of parson who of CHALL I . MARGO	completed cause of death (Iter	n 23a) (Type, Pri	int) < VIUTE	DIKE, Re	challet,	mo 208	352	
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's Signa		Sport					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death **Physician** 9:58 P.M. ELIZA GUSSIE 4b. City, Town, or Location of Death 1999 /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Holy Cross Hospital Birthplaca (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 90 Yrs. Feb. 10, 1909 Va. Director 218 10 8496 Usual Residence of Decedent with the Merylend 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23s or 28s-(show traumstic event, tre Mexical Examinar must be notified at Md. Montgomery Silver Spring 1 ☐ Yes 🌪 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Mariner Health Care Center deeth v Funeral 20904 U.S.A. 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritei Status permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health end Mental hygiene. Important: If item 27 is merked other than "natural", or iter any injury or other fraumatic event, the Mexical Examina DRS. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify 2 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 LPN Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Sarah Musser Elijah J. Harner 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Randolph Rd. APT. 229A Silver Spring, MD 20904 Mrs. Doris Harne (Daughter) 20b. Place of Disposition (Name of cematery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBuriel 2 Cremation 3 Removal from State 5/7/99 Springfield Cemetery Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) 21, Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complication, that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory affect, shock, or heart failure. List only one ceute on such line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical **Examiner** Due to (or as a consequence of) Examiner attanding physician end for use as the burial-transit law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Box 68760 Physiclan/Medical Due to (or es a consequence of): signed by the a P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of deeth? lehydrotion 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? been sig 24e. Was en autopsy performed? Completed ate has bage 2 s The 1 Yes 2 LA certificate Division of Vital Physicien: 25. Was case referred to medical examiner? director Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 LNd 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Certification: or Attending 5 Pending 1 Negural To the Hospital or Attendin within 24 hours efter deeth. To the Funeral Director: Af complately filled in by the fu 1 Yes 2 No deeth. investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print) B.N. ROSENBADM 3720 FARRAGUT AUS. KENSINGTON, MD. 20895

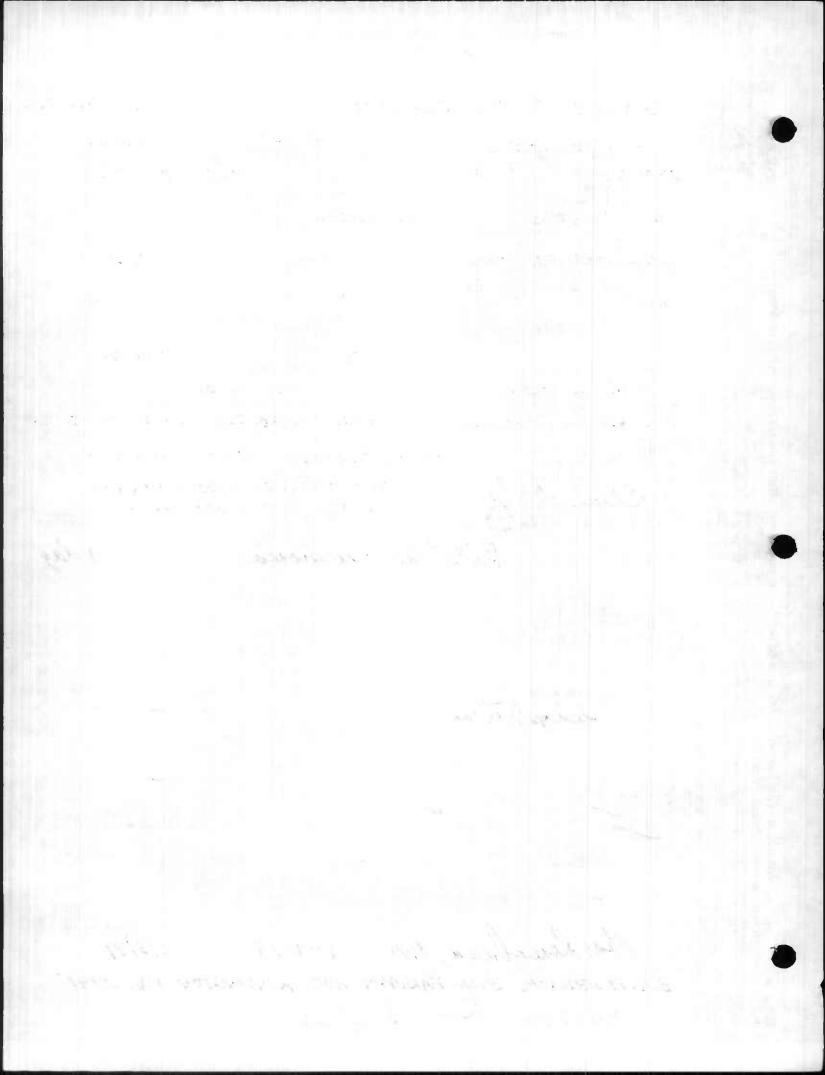
DHMH 16 Ray 6/95

Registrar

31. Date filed (Month, Day, Year)

MAY 0 5 1999

32. Registrar's Signature



State of Maryland / D

epartment of Health and	Mental	Hygiene	9	1
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Physic /Medi		1. Decedent's Ner Josephir	ne (First, Middle, ne Naylor (2. Dete of D. Month 2,	eath 1999 ⁹	Year 3	Time of Death 4:20 AM
Exami		4e. Fecility Neme	(If not institution, s		umber)				own, or Lo	cation of Dee	th 4c. Count	y of Deeth	
Funeral Director		5. Sociel Security 214–52–5787	Number 6	. Sex 1 □ M 2 🔀 F	7. Age (In yrs	83 Yrs.	If Under 1 Y Months Do		24 Hrs. Min.	8. Data of Bi (Month, D	irth	9. Birthplece Country)	ston, D.
pu »		Usuel Residence of			10- 0					Aug.			
aryle show	_	MD.	10b. County	ما ما۔	10c. C	ity, Town or L							Inside City Limit
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th with th	Funeral Director	10e. Street and Nu	^{umber} 06 Sumanto	an Rd.			10f. Zip Co	de 21.769			10g. Citizen of U.S		
tar dea	by		ried 2 Married	Armed F	2 X No	U,S. 13.	Was Decedent If Yes, specify 1 ☐ Yes 2X			ecify Yes or N Rican, atc.)	o- 14. Ra Ble Specii	ce - American I ock, White, etc. fy: Whi	
72 hours	ted	/Cno	15. Decedent's ecify only highast	Education	1	16e. Dece	dent's Usuel O	ccupetion			16b. Kind of B	Business/Indust	ry
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and be file tal Hys d othe event,	9	17. Fether's Neme	(First, Middle, La	st)				18. Moth	er's Name	(First, Middle	e, Meiden Sumei		
Maryland 2 should be filed the end Mental Hygi i? Is marked other traumatic event,	ToB	Mi.1	Ltan Naylar	•				M	arie I	Faloran			
Maryla d 2 should th end Men 7 is marks traumatic	-	19e. Informent's N	Jame/Reletionshir	(Type Print)		19h Meili	nn Address (St				ber, City or Town	State Zin Co	del
N d d d d d d d d d d d d d d d d d d d		Frank Mann		(1)/00/11/							-	, Siele, 210 001	10)
					20h		Sumanto		MICCHE			01: =	ALUE TO THE PARTY OF THE PARTY
2 2 2	1	20a. Method of Dis	Sposition Cremetion 3	□Removel from	State 200.	cematery, cre	osition (Neme of metory or other	plece)	1	Date	20c. Location	- City or Town,	Stete
altim nit. Par antmen ortant: Injury			5 ☐ Other (Spe-		Gat	te of He	aven Cema	tery	5,	/7	Silver S	oring, M).
Baltimore, permit. Pages 1 et Department of Hea Important: If Item 2 sny Injury or other once.		21. Signeyare of F	uneral Service 05	Tast	2	D 3	2. Name end Ad Chald B. L E. Mair	Thampson St., Mid	ty Funer ddleto	cal Home	21769		
Physician /Medical Examiner		23a. Pert1. Enter shock, or her Immediate Ceuse disaasa or conditi resulting in daath)	(Finel		aused the dee eech line. 14xedl Due to (dying, such es	cardiac c	er respiretory e	errest,	On	proximete arval Between set and Deeth
O, axecuted an and inal-transit	Examiner	Sequentially list or if eny, leeding to licause. Enter Und Ceuse (Disease or thet inflieted event resulting in deeth)	onditions, mmediete lerlying	b. H		or es e conse						y	lears
ox 68760, n certificate be executed anding physician and use as the bunial-transit	in/Medical Examiner	Ceuse (Diseese or thet initiated event resulting in deeth)	r injurý Is Lest	c	Due to (or es e consec	quence of):						
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D za D	by Physicia	Serri	ure dus	order	Seve	ne de	emente	a		1	Yes 2010	3 Probabl	y 4 🗆 Unkno
aw requise been 2 should	Completed		· · · · · · · · · · · · · · · · · · ·				-1				s an autopsy omed?	aveilet	autopsy findings ble prior to ation of cause th?
The Late he page	S									1□	Yes 2 No	1 □ Ye	s 2 No
of Vital I Physician: The this certificate	Be	25. Wes case refe exeminer?	rred to medical					26. Place	of Deeth	(Check only	one)		
Of V	2	1 ☐ Yes 2 ☑	No	Hospitel:	inpatient 2	ER/Outpetie	nt 3 DOA	Other: 4 No	ursing Hor	me 5□Res	idence 8 Oti	her (Specify)	
E 5 5 5		27. Menner of Dee 1 Di Neturel 2 Accident	5 Pending Investigat	ion	of Injury oth, Dey Year)	28b. Time o Injury		Injury et Work? 1 ☐ Yes 2 ☐	:		how injury occur		
Division To the Hospital or Attending within 24 hours after death To the Funeral Director: After completaly filled in by the funa	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	200. 1100	e of Injury - At h ling, etc. (Speci		reet, fectory, off	ice	1		(Street end Num. own, Stete)	ber or Rurel Ro	ute Number,
Hospit 24 hour 10 Funers	edical (29a. Certifier (Check only one)	1☑ Certifying I 2☐ Medical Ex	aminer: On the t	e best of my kno pasis of exemina oner stetad.	owledge, deet etion end/or In	h occurred et th vestigetion, in r	e time, dete en ny opinion, dee	d plece, e	and due to the ed et the time,	ceuse(s) and m date end place,	enner as stated and due to the	i. ceuse(s)
To the To the Comp	X	29b. Signeture end	d title of certifier				29c. Lic	ensa number		T	29d. Data signe	ed (Month, Day	Year)

ave, Brunswick, Hd. 21716

State Registrar

31. Dete filed (Month, Dey, Year)

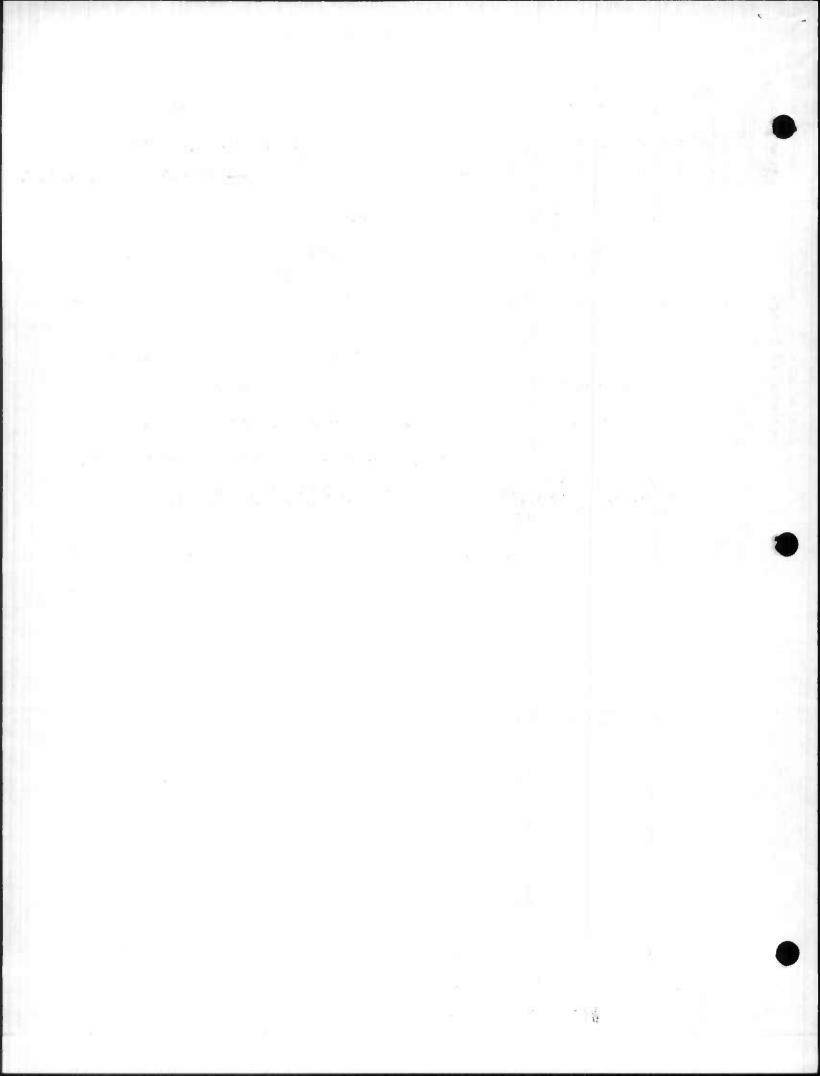
Kathleen W Stern W

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kathleen W Stern ND, 610 Ninth

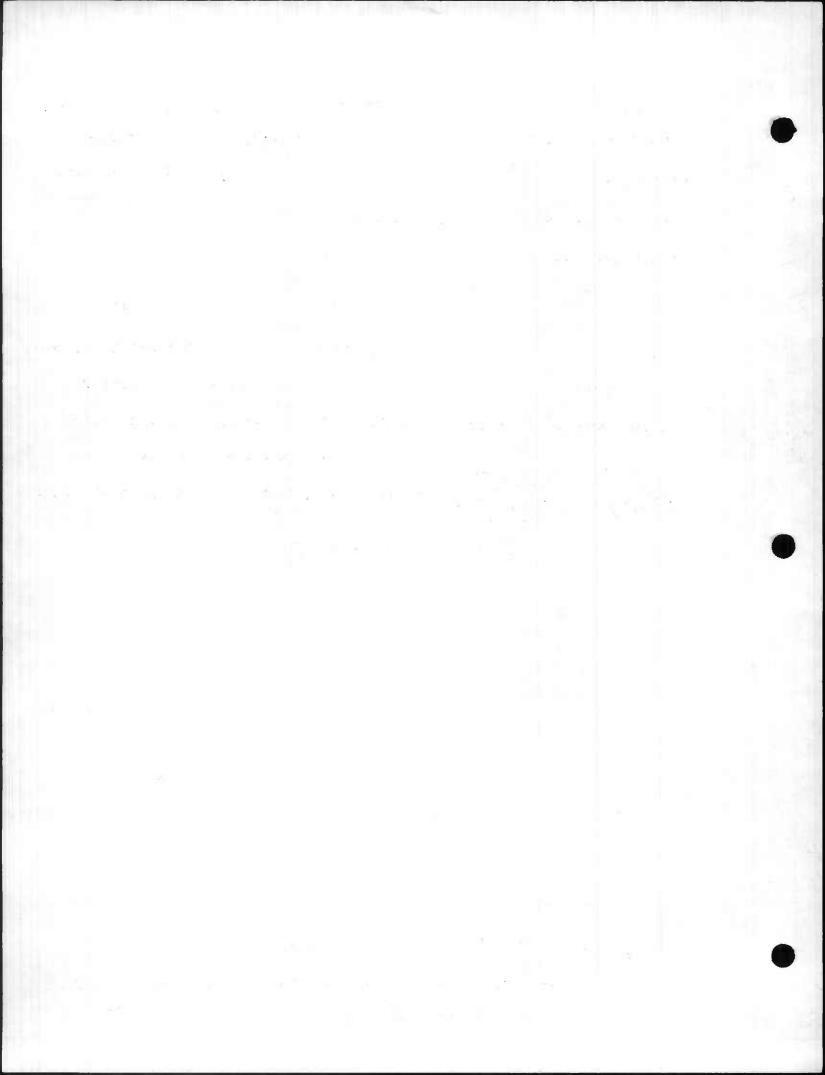
MAY 04 1999

32. Registrar Signature



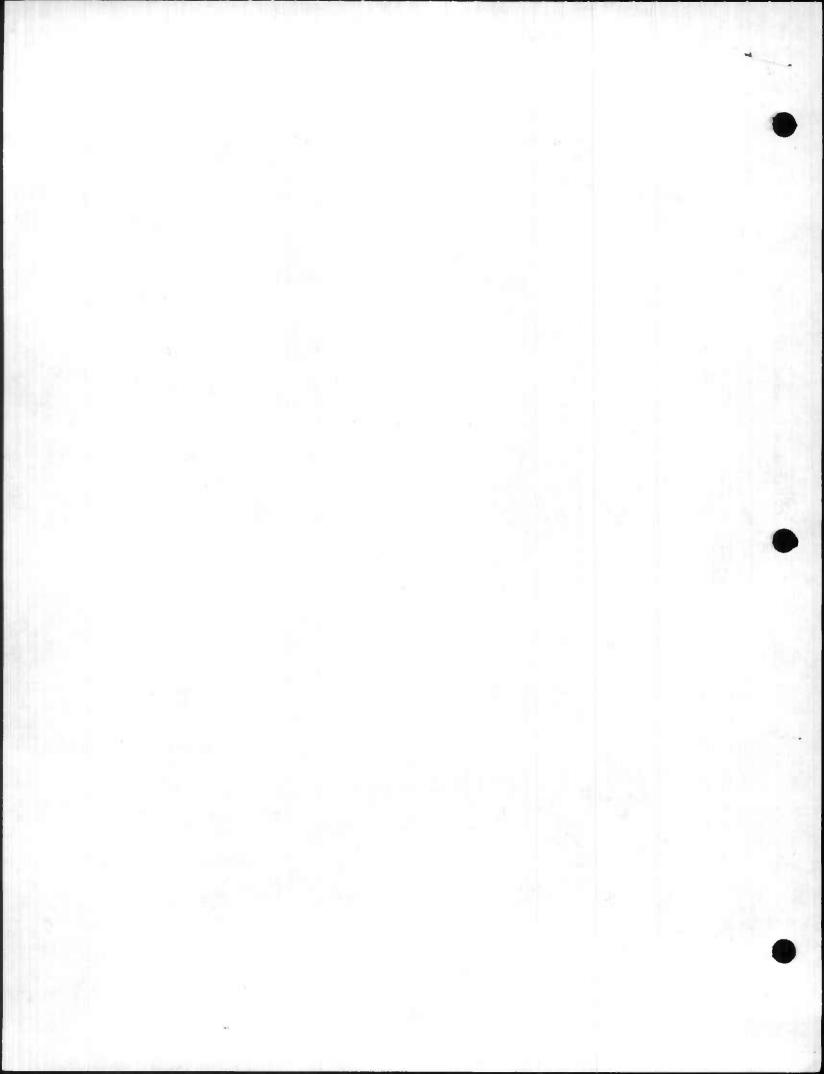
State of Maryland / Department of Health and Mental Hygiene

		Ce	rtificate	e of L	Death		Reg. No.	r'	0211
Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
Patricia	L.		Chap	-		MAY		199	1:03pm
4a Facility Name (If not institution, give st				4	b. City, Town, or L	ocation of Death	4c. Coun	ty of Death	
CIVISTA MEDICAL CE	NTER				LAPLAT		1	CHARLI	ES
5. Social Security Number 6. Sex 214-58-0357 Usual Residence of Decedent	7. Age (In	yrs. last birthday Yrs.	Months Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da May 21	th y, Year) 1,50	Coun	lace (State or Foreign 7 Land
10a. State 10b. County	10	c. City, Town or L	ocation					10	Od. Inside City Limits
Maryland Charles	1	lughesv	ille						1XX Yes 2 □ No
Maryland Charles 10e. Street and Number		rugiicu	10f. Zip	Code			10g. Citizen of	f What Coun	Irv?
				2063	27		-	S.A.	
13310 Oaks Rd 11. Merital Status 1 Never Married 2 Married	2. Wes Decedent Ever	in U.S. 13.				pecify Yes or No		ace - America	
1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Yeer or Dates:		If Yes, spec 1 ☐ Yes 2		ispanic Origin? (S) n, Mexican, Puerto Specify:	o Rican, etc.)	Spec	eck, White, o	
15. Decedent's Educa	ation	16a. Dece	edent's Usua	Occupa	atlon		16b. Kind of		
15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 1.2	Completed) College (1-4or 5+)	(Give	B kind of wor DO NOT us	k done d	during most of wor	king			
12	College (1-401 3+)	Sp	ecial	list	-		Federa	1 Gov	vernment
17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle,	Maiden Suma	ame)	
Unknown					Charo	lette		Winte	ers
19a. Informant's Name/Relationship (Type	e, Pnint)	19b. Mait	ing Address	(Street 8	and Number or Ru	ral Route Numb	er, City or Tow	m, State, Zip	Code)
Jerome Chapman	Husband	13310	Oaks	Rd.	Hughes	ville I	Maryla	ind 20	0637
20a. Method of Disposition		Ob. Place of Disp	osition (Nam	ne of		Date	20c. Location		
1 Buriai 2 Cremation 3 Red 4 Donation 5 Other (Specify)		nion Be				7.99	Brandy	wine	MD
21. Signature of Furniral Service Licenses			22. Name and			. ,			
7111 2					eral Ho	mo D o	λαμος	co Mi	20608
X May C					The same of the sa			SCO FI	
23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	cause on tech line	meath. Do not en	iter the mode	e or ayını	g, such es cardiac	or respiratory a	rrest,		Approximate Intervat Between Onset and Death
	0 -								Oriset and Death
Immediate Cause (Final disease or condition	BRE	AST	CA	40	ELL				
resulting in death) a.	Due	to (or as a conse	equence of):					i	
								i	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a conse	equence of):						
that initiated events resulting in death) Last	Due	to (or es e conse	quence of):					1	
and the second second									
d									
Part ii. Other significant conditions contr	ributing to death but no	ot resulting In the	underlying ca	ause give	en In Part i.	23b. Dld	tobacco uss o	contribute to	the cause of death?
Cause (Disease or injury that initiated events resulting in death) Last Deart II. Other significant conditions control						10	Yss 2□ No	3 □ Prol	bably 4 Waknown
						24a. Was	an eutopsy	24b. We	are autopsy findings
							ormed?	co	aitable prior to mpletion of cause
									death?
						1 🗆	Yes 2 No	10	Yes 2□ No
25. Was case referred to medical examiner?	anitat.	-		60	26. Place of Dea	ath (Check only	one)		
1 ☐ Yes 2☐ No		ER/Outpatie			4 U Nursing H	lome 5 Resi			y)
27. Manner of Death	28a. Date of injury (Month, Day Ye	28b. Time (of 2	8c. Injun Worl	y at k?	28d. Describe	how injury occ	urred	
2 Accident Investigation			М		Yes 2□No				
3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - building, etc. (S	At home, farm, sipecify)	treet, factory	, office		28f. Location (City or To	Street and Nur wn, State)	m <i>ber</i> or Rura	il Route Number,
4 Homicide determined					ne date and piace	, and due to the	cause(s) and i	manner as s	lated
4 Homicide determined	cien: To the best of mer: On the basis of exa	y knowledge, dea mination and/or i	th occurred a nvestigation,	in my of	pinion, death occu	rred at the time,	date and place	e, and due to	the cause(s)
29a. Certifier Certifying Physic (Check only one)	cien: To the best of more: On the basis of exa	y knowledge, dea imination and/or in	nvestigation,	in my of	pinion, death occu	rred at the time,			the cause(s)
29a. Certifier Certifying Physic (Check only an Medical Examine	er: On the basis of exa	y knowledge, dea mination and/or in	nvestigation,	in my of	pinion, death occu	rred at the time,	29d. Date sign		the cause(s)
29a. Certifier Certifying Physic (Check only one)	er: On the basis of exa	y knowledge, dea mination and/or in	nvestigation,	in my of	pinion, death occu	rred at the time,			the cause(s)
29a. Certifier Certifying Physic (Check only one)	er: On the basis of exa and manner stated.	mination and/or in	nvestigation,	in my of	pinion, death occu	rred at the time,			the cause(s)
29a. Certifier Certifying Physic (Check only one) 29b. Signature and title of certifier Certifier Certifier Certifier Authorized Physics Certifier	er: On the basis of examination and manner stated. Here of the basis of examination and manner stated. The basis of examination and manner stated.	mination and/or in (them 23a) (Type bridge P	29c	in my op	pinion, death occu	rred at the time,	29d. Date sign	ned (Month,	the cause(s)



State of Maryland / Department of Health and Mental Hygiene

		7.0		Certifica	e of	Death		R	eg. No.	133	3.10
DI	1. Decedent's Neme (First, Middle, La.	st)						. Dete of Deat		Year	3. Time of Deeth
Physician 'Medical	Sydney Ann I	Dickson				اللاث	1	May 3,1	.999		11:00pm
Examiner	4a Facility Name (If not institution, giv-						wn, or Loca	ition of Death	4c. County	of Death	
	Holy Cross Hosp					Silve	r Spr	ing		gomery	
Funeral Director	none	ex 7. Age (i	n yrs. last biri	Yrs. If Under	Deys	Hours 1	Min. 22 1	Dete of Birth (Month, Day, May 3, 1	999	9. Birthplac Country Mary	land
2	Usual Residence of Decedent 10a. Stete 10b. County	11	0c. City, Towr	or Location						10d.	Inside City Limits
or 28a-f she be notified a Director	Maryland Montgom	ery	Gaithe	rsburg	0.45						1∭ Yes 2□No
ter death with the Maryland flems 23e or 28e-f show ther must be notified at funeral Director	754 Quince Orchar	d Blvd., #2	201	20	878			ı	Og. Citizen of V United		
_ 3 # # E	11. Merital Status 1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:	er in U,S.	13. Was Dece If Yes, spe				ify Yes or No- can, etc.)		e - American ok, White, etc	
ad within 72 ho ogiene, wr then "natum 4, the Medical.] Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usu (Give kind of we life. DO NOT a	el Occup	pation during mos	t of working	7	16b. Kind of Bu	siness/indus	itry
uple and	Elementary/Secondary (0-12)	College (1-4or 5+)			se retire	d)			-/-		
Hedra Hade	17. Father's Neme (First, Middle, Last)		n/	a		10 Mothe	ar's Name (Circt Middle I	n/a Maiden Sumam	a)	
id be fi entall h med out	Darryl Anthony D	ickson							Cooper	16/	
Thou was	19a, Informant's Name/Reletionship (Type, Print)				end Numbe	er or Rural I	Route Number	, City or Town,		ode) 20878
1 end 1 Health em 27 other tr	Darryl Anthony I			-			q BIA				
Dallimore, Ma Department of Health er Important: if fee 27 la any injury or other treu	20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Hemover from State		Disposition (Na y, cremetory or peake C			5-		20c.Location - Beltsvi		aryland
Baltimor permit. Pages ' Department of I important: If its any injury or of pages.	21. Signature of Funerel Service Licer	see						s, P.A		awy1 a	4 20010
	23a. Pert1. Enter the disease, or com- shock, or heart feilure. List only	plications that caused the	e deeth. Do r						ring, M		nd 20910
death certificate be executed Wedical Wedical We estending physicien and od for use as the buriel-transit sician/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Chorioam Du Preterm	e to (or es a c nionit e to (or es e c labor	consequence of)							
	resulting in death) Lest	d	e to (or es e c	onsequence of)							
P.O. d by th detach;	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying	cause gi	ven in Pert I	l.	23b. Did to	V		ne cause of death? bly 4 ☐ Unknown
aw requir								24a. Was a perion		availe	autopsy findings able prior to pletion of cause ath?
T : 4 5								1 🗆 Y	es 20 No	1 🗆 Y	res 2□ No
oertificata irector, pag	25. Was case referred to medicat examiner?					26. Place	e of Deeth	Check only or	18)		
- 5 5 D	1 Yes 2 No	Hospitel: Inpatient	2 ER/Ou	tpatient 3 D	OA OI	her: 4 Nu	ursing Home	e 5 Reside	ence 6 Oth	er (Specify)	
Attending Physical Colors of the funeral diffication: Te	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Y	ear) 28b. 1	ime of njury M	28c. Inju Wo 1	ryet rk?]Yes 2□		d. Describe ho	ow injury occur	red	
DIVISION (but or Attanding Para after deeth.) In Director: After ted in by the funer. Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, fe Specify)	rm, street, fecto	y, office		28	of. Location (Si City or Town	treet end Numb n, State)	per or Rural R	Route Number,
DIVISION O To the Hospital or Attending Pt within 24 hours after deeth. To the Funerel Director: After th completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one)	ysician: To the best of m iner: On the basis of ex and menner steted	aminetion en	, deeth occurred Vor investigation	et the ti	me, dete en opinion, des	nd place, en eth occurred	d due to the c	ause(s) end me ete end piece,	enner es state and due to th	ed. ne cause(s)
To the company of the	29b. Signature and title of ourtilier	n mo		29	D341	se number			9d. Date signe May 6,		ly, Year)
	30. Name and address of person who Carolyn J. Harring			Type, Print) nestown	Rd	Potom	nac Md	20878			
State Registrar	31. Date filed (Month, Day, Year) MAY 0 7 199	32. Registrer's		9. Spo	uh	/					



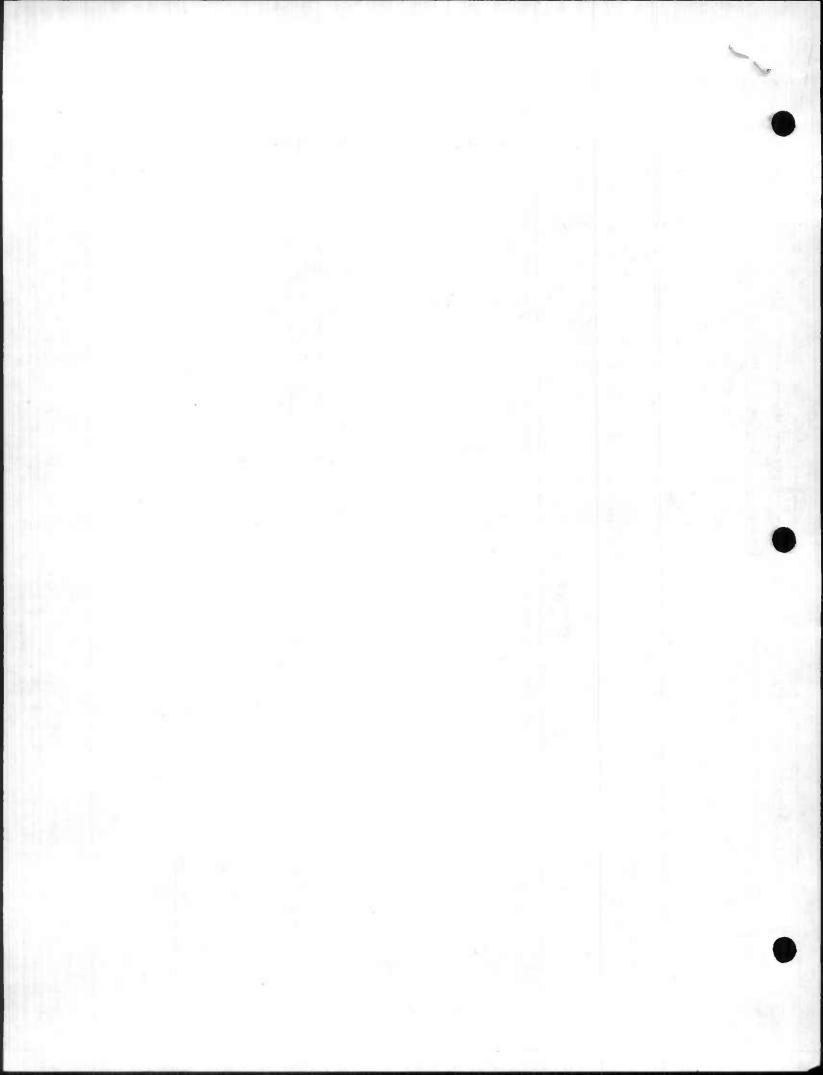
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #20b, 5/10/99, BMW, Montg. Co. Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** L. 1999 12:30 AM Benjamin Danner May 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Center
ocial Security Number 6. Sex 7. Age (In yrs. last birthday) Wheaton Montgomery 8. Date of Birth (Month, Day, Year) Jun. 20,] If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 78 059-16-4715 Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director ral", or items 23a or 28a-f Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5303 Flanders Avenue 20895 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian, Amed Forcas:
1 X Yes 2 No 1939
If Yes, Give 1945 Black White etc. filed within 72 hours after 1 ☐ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ Electrical Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) . Peges 1 and 2 should be lik ment of Health and Mental He ant: If Item 27 is marked oth jury or other traumatic even Be Louis Danner Viola Garrison 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Elizabeth M. Danner / Wife 5303 Flanders Avenue, Kensington, Maryland 20895 20b. Place of Disposition (Name of cametary, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State permit. Peges 1
Department of H
Important: If Ne
eny Injury or ott
once. 10 1 N Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 5/8/1999 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final neumonia disease or condition rasulting in daath) Examiner Due to (or es a consequence of): Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.O. been signed by ta should be detach 1 Yes 20 No 3 Probably 4 Unknown Records. p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 a 2 0 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? of or Attending Peter death. 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di., completely filled in 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 034032

11 O

> State Registrar

31. Date filed (Month, Day, Year) 071999 Registrar's Signature

to completed cause of death (Item 23a) (Type, Pint AVE KENSINGTON MD



State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Dey Month **Physician** 1999 Ruth Hollenbeck Davis 6, 8:40 A.M. May /Medical 4e Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 8628 Garfield Street Bethesda Montgomery If Undar 1 Yaar If Under 24 Hrs. Birthpiaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) **Funeral** Deys Hours 1 M 2 M F Months 215-46-2476 89 **Director** September 17,1909 Ohio Usual Rasidance of Decedant the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8628 Garfield Street 20817 United States Funeral death 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Pages 1 and 2 should be filed within 72 hours after imment of Health and Mental Hygiene.
 If them 27 Is marked other than "natural", or item into or other traumatic event, in a feed an intervent or other traumatic event, in a feed as it can intervent. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: by 3 X Widowed 4 ☐ Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Clarence M. Hollenbeck Elice Penfield 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Susan Davis Snyder/ Daughter 8628 Garfield Street, Bethesda, Maryland 20817 20b. Place of Disposition (Nama of camatary, cramatory or other place) May 7, 1999 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burlal 2 X Cremetion 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Othar (Specify) Bethesda, Maryland ature of Funeral Se 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 plications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Brain Cancer 2 months Examiner Dua to (or as a consaquance ot): Examiner certificate be executed ettending physician and for use as the buriel-transit Sequantially list conditions, if any, laading to immediata ceuse. Enter Underlying Causa (Diseasa or Injury that Initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ should t 24b. Wara autopsy findings available prior to Completed 24a. Was en autopsy performad? complation of ceusa of death? 1 ☐ Yas 2 🖾 No 1 ☐ Yas 2 ☐ No certificata Division of Vital director, Be 25. Was cesa rafarred to medicel axeminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 X Residence 8 Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Affer Injury 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No death. 2 Accident investigation or Attand after death Director: 6 Could not be datarmined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida Hospital 24 hours a Funeral D 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

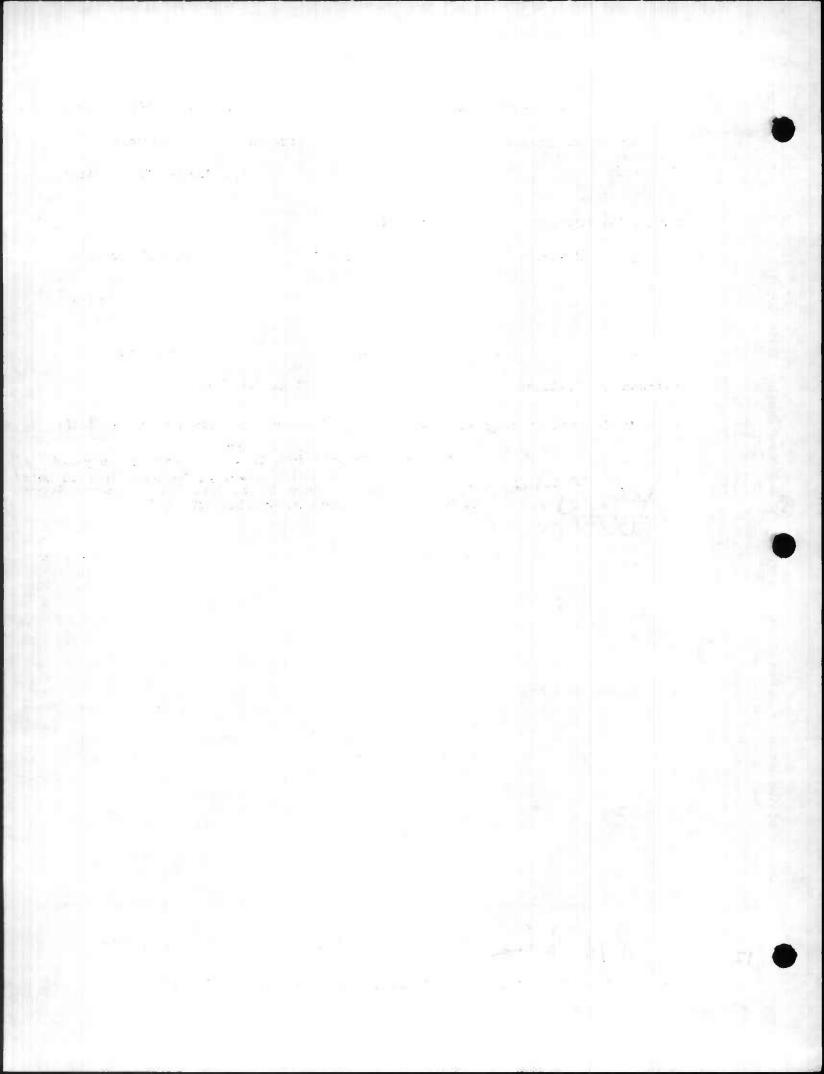
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical completely (Check only one) To the To the F 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) May 6, 1999 D01191 aple 12 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) Ralph M. Coan, M.D. 9618 Culver Street, Kensington, Maryland 20895

State Registrar 31. Data filad (Month, Day, Year)

MAY

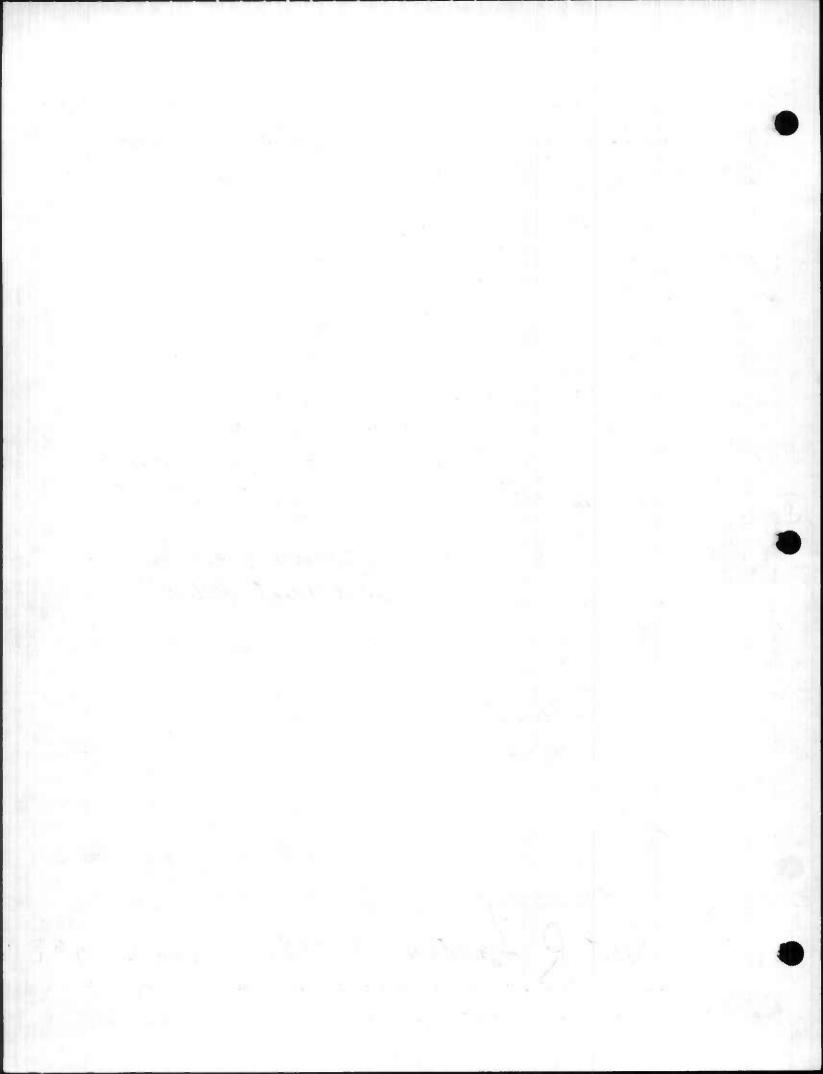
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32 Fegistrar's Signatura



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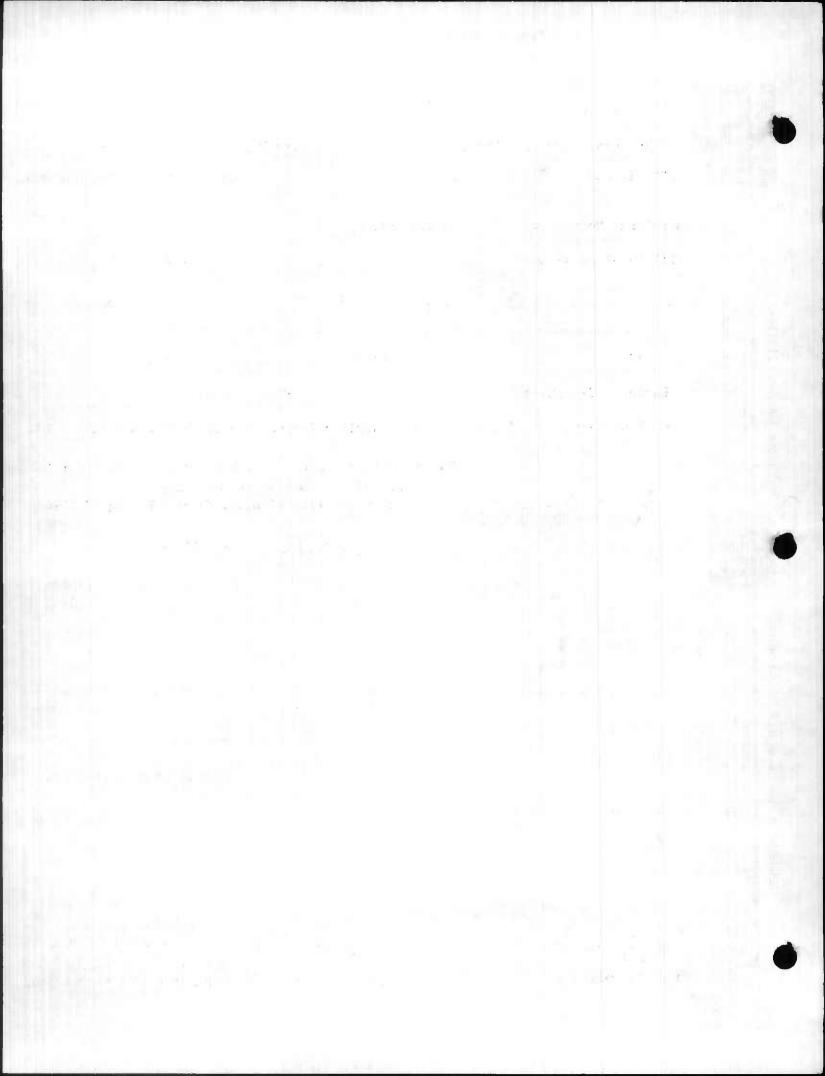
			91		iviaiyiai		ertificate of			Reg. No.	9	5981
Physic	ian	1. Decedant's Nama (Fi	rst, Middla, La Edel						2. Data of Da Month May	ath Day	19 ^{Yea}	3. Time of Seath
/Medi		4e. Facility Nama (If not			her)			4b City Town	or Location of Daath		nty of Death	3:05 WH
Exami	ner	Rockville I			50,7			Rockv			itgome	rv
Funeral Director		5. Social Sacurity Numb	1	ax 7	. Aga (In yrs.		If Undar 1 Yaar Months Days	If Undar 24 Hours	Hrs. 8. Data of Bin Min. (Month, Da June 27	th y, Year) 1911	9. Birthi Coul New	placa (Steta or Foreign ntry) Jersey
ylend		Usual Rasidanca of Dec 10a. Stata 10i	edant c. County		10c. Cit	y, Town or L	ocation				1	10d. Insida City Limits
Ba-f s	Director	MD 1	Montgom	ery	Roc	ckvill	e					1 XYes 2 No
E 22	Dire	10e. Straat and Numbar					10f. Zip Coda			10g. Citizan		ntry?
e 23e	erai	303 Adclar	e Road	40.144		2	208				JSA	
5-0020 72 hours after deeth with the Maryland natural', or items 23a or 28a-1 show steel Examinat must be notified at	by Funeral	11. Marital Status 1 □ Navar Marriad XX Widowed 4 □		12. Was Deced Armed Ford 1 Yas 2 If Yas, Give Yaar or Dat	as? XNo	,5. 13.	Was Dacedant of F If Yas, specify Cuba 1 ☐ Yas 2 ☐ No	ispanic Origin' an, Maxican, P Specify:	? (Specify Yas or No uarto Rican, atc.)		Race - Amaric Black, White, Cify: Whi	atc.
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nd 212 e filed withi al Hygiene. other than	Co	12 17. Fathar's Nama (First	, Middla, Last)	· ·		ROOK	keeper	18. Mothar's	Nema (First, Middla,	-	nalmol	ogy
lan id be ental ked o	To Be	Joseph Wol							e Chrzstov		ina)	
ary shou and M	-	19e. Informant's Name/		Type, Print)		19b. Mail	ing Address (Straet		r Rural Routa Numb		vn, Stete, Zip	Coda)
end 2 ealth an 27 li		Paula Kahn	/Daught	er		14416	Pecan Dr	ive. Ro	ockville,	MD 2	20853	
Baltimore, semit. Pages 1 el Depertment of Hea mportant: If Item any Injury or other anse.		20a. Mathod of Dispositi	on		20b. P	laca of Displamatary, cre	osition (Nama of metory or other place	oa)	Data		n - City or To	own, Stata
timent: Pag tment: tant:		4 □ Donation 5 □	Othar (Specify	1)			on Cemete		5/9/99	Flushi	ing, N	Y
Baltimore, Maryland 'permit. Pages 1 end 2 should be filed Depertment of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, once.		21. Signature of Funara 23a. Part1. Entry the dishook, object fail	alel	1/2		2	2. Nama and Addra 54 Carrol	1 Stree	Takoma Fu	hingto		20012
BOX 68760, asth certificate be executed xx xx etimological and with the control of the control o	n/Medical Examiner	tmmedieta Cause (Fine disaasa or condition rasulting in daath) Sequantially list condition if any, leeding to immediates. Entar Undarlying Causa (Disaasa or thjurthat initiated events rasulting in death) Last	ons, late	a	Due to (o	r as a consecutive as a	Mence of):	hem	t fan	lend		
Geath death	sicial	Part II. Other significant	conditions co	ontributing to deal	th but not resu	ulting In the u	ındadvina causa aiv	an in Part I	23h Did 1	obacco usa	contribute to	the cause of death?
IS, P.O. BOX (set that the death certification of the ottending be detached for use a	y Physician/M		- 1		-	aning in the c	moanying causa giv	an III Fait I.				bably 4 Unknown
HECOTGS, P.O. BOX The law requires thet the death cent te has been signed by the ettending page 2 should be detached for use	Completed by		de	ement	1				24a. Was perfo	an autopsy mad?	av	ara autopsy findings ailabla prior to mpletion of cause daath?
The law	Mo				1				101	as 20 No		□Yas 2□ No
ystclan: The last certificate had director, page	Be	25. Was casa refarred to axaminer?	-					26. Placa of	Daath (Check only o	na)		
JIVISION OF VITAL HECORDS, or Attending Physician: The law requires the first death. Director: Atter this certificate has been signed in by the funeral director, page 2 should be	5	1 ☐ Yas 2 ☐ No 27. Menner of Death	Pending invastigation			ER/Outpatle 28b. Time o Injury	f 28c. Injur Wor	4 Nursin	g Homa 5 Rasid			v)
UNISION OF To the Hospital or Attending Phy within 24 hours effector. After this completely filled in by the funeral	Certification:	3 ☐ Suicida 6 [4 ☐ Homicida	Could not be datarmined	28a. Placa of	Injury - At ho , etc. (Specif)	ma, farm, st	reat, factory, office		28f. Location (5 City or Tox	Straat and Nu m, Stata)	m <i>ber or R</i> ura	il Routa Number,
DIV To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b	edical	29a. Certifiar 12 (Check only one)	Certifying Phy Medical Exam	rsician: To the be iner: On the basi and manny	s of axaminat	vledga, daat lon and/or in	h occurred at tha tim vastigation, in my o	na, data and pl pinion, daath o	eca, end dua to tha occurred at tha tima, o	cause(s) end data and plac	menner es s e, and dua to	teted. tha causa(s)
D Stiff	2	29b. Signaturyrand title o	tk) 2	oldel	LIM	29c. Licenso	358	7	Man	ned (Month,	Day, Year)
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Sta Registr		31. Data filed (Month, De		32. Reg	Istrar's Signal	ture	Spork		ornedda, 1	2	5514-1	. 55



State of Maryland / Department of Health and Mental Hygiene

15982

			Certificate of	Death	Reg	g. No.	
	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ye	3. Tima of Death
Physician	JACK E. EIS	EN HART			MONTH	Day Yes	
/Medical Examiner	4a Facility Neme (If not institution, give street an			4b. City, Town, or Lo		4c. County of D	eath
LAGITIFICE	Washington Adventist	Hoonital		Takema Da	u-1-	Wantaa	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year		8 Date of Birth	Montgo	mery Birthplace (State or Foreign Country)
Director	579-26-2680 12 M 2	F 73	rs. Months Deys	Hours Min.	(Month, Day, 1		shington, D.C.
	Usual Residence of Decedent	1.5			may II,	1925 Wa	SHIIIgron, D. C.
ome 23s or 28s-f show if must be notified at neral Director	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
el, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	Maryland Montgomery	Cd 1wa	r Spring				1 ☐ Yes 2 No
or 28a-f s be notified Director	10e. Street and Number	SILVE	10f. Zip Code		10	g. Citizen of What	Country?
o a a	9512 Caroline Avenue		2000	\1		7.C.A	
E E		Decedent Ever in U,S.	2090 13. Was Decedent of	Hispanic Origin? (Spe	city Yes or No-	USA 14. Race - A	American Indian,
iner must	Arme	d Forces?	if Yes, specity Cui	ban, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
bolical Examination	3 ☐ Widowed 4 ☐ Divorced Year	res 2 □ No s, Give or Dates: ₩₩ II	1 ☐ Yes 21 No	Specify:		Specify:	White
# P	15. Decedent's Education	***************************************	Decedent's Usuai Occu	ination	10	6b. Kind of Busine	
ie ie	(Specify only highest grade comple	ted)	(Give kind of work done life. DO NOT use retin	during most of worki	ng		,
other traumatic event, tra Medical I	Elamentary/Secondary (0-12) Cottle	ge (1-4or 5+)					
£ 0	17. Fether's Name (First, Middle, Last)	Ma	nagement	18. Mother's Name		Pepco	
matic ever				10.10011010101101	(1.1701, 1110010, 111		
2	Charles Eisenhart			Edna	Devers		
2	19a. Informent's Name/Relationship (Type, Print) 19b.	Mailing Address (Stree	et and Number or Rura	I Route Number,	City or Town, Star	te, Zip Code)
5	Ida Eisenhart (wife) 95	12 Caroline	Avenue	Silver S	pring, Ma	ryland 20901 or Town, State
	20a. Method of Disposition		Disposition (Name of y, crematory or other pl	ace)	Date 2	Dc. Location - City	or Town, State
any injury or once.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)		ville Cemet	oru 5	/8/00 Ca	1	,Maryland
any injury once.	21. Signature of Funeral Service Licensee	TOOLESV	22. Name and Add	ress of Fecility			
eny i	11		Francis J.				
	23a. Part1. Inter the disease, or complications	hat says and the death. Do n	500 Univer	sity Blvd	.W.,Sil	ver Spri	ng, MD 20901
	shock, ir heart failure. List only one cause	on each line.	ot enter the mode of dy	ring, such es cardiac t	or respiratory arres	51,	Interval Between Onset and Death
ian	The state of the s		0 0 0	Λ. Λ	051	- 1.	
ical ner	Immediate Cause (Final disease or condition	NZRRU	CFIE	BAIC	S. FW.	(4)	
		Due to (or as a c	consequenca of):	1887 DWC		A DC	40
ie ie	_, 0	o BONAS.	1 4 be	115 KX	0128	54)), 15	Year
Examiner	Sequentially list conditions,	Due to (or as a c					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.						
se as the bu	that initiated events	Due to (or as a c	onsequenca of):				
d =	resulting in death) Last	`					
	d						
Physician	Part It. Other significent conditions contributing	to dooth but not reculting in	the underlying seven	iven in Dart I	22h Did toh	anno una contrib	outs to the causs of death?
deteched for u	Partit. Other significant continuous continuous	to death but not resulting in	the dildenying cause g	ivoir iir r ait i.			Probably 4 Onknown
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should be detect					24a. Was an	autoney 2	4b. Were autopsy findings
Š					perform		avaltable prior to completion of cause
N D				7			of death?
ral director, page 2 should . To Be Completed					1 ☐ Ye	s and No	1 ☐ Yes 2 ☐ No
Be C	25. Was case referred to medical			26. Place of Deat	n (Check only one)	
TO B	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 SER/Ou	tpatient 3 DOA	ther: 4 Nursing Ho	me 5 Resider	nca 6 Other (Specify)
i	27. Manner of Death 28a.	Date of Injury 28b. T	ime of 28c. fnj		28d. Describe hor		
10	1 Straturat 5 Pending 2 Accident investigation	Month, Day Year)		ork? ☐Yes 2☐No			
y the	3 Suicide 6 Could not be	Place of fnjury - At home, far	m. street, factory, office	9	28f. Location (Str.	eet and Number o	or Rural Route Number,
Certification:	4 ☐ Homicide determined 258.	ouitding, etc. (Specify)	,,,		City or Town,		
Ö	200 Conffict		dash as an and at the	en determine		(-)	
edical	29a. Certifier (Check only one) 1 Certifying Physician: T	he basis of examination and	, death occurred at the d/or investigation, in my	time, date and piace, opinion, death occuri	ed at the time, da	use(s) and manne te and piace, and	due to the cause(s)
completely filled in by the funer Medical Certification		menner steted.	20a Lion	nee oumber	20	d Date signed (I	footh Day Vens
8	29b. Signature and title of cartifier		29C. LICE	nse number	29	d. Date signed (N	ignin, Day, rear)
•	Indiator		101	1991		OXIO	(1779
	30. Name and address of person who completed	cause of death (item 23a) (Type, Print)	ucc Ar	4230		Md
/	K. ZN DHYYYBE W	0 7610	CAKK	UCC 417	F TAKO	mA PAR	ck. 20912
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	, ,			,	
egistrar	MAY 071999	Geneva &	1. Soork	1			
	111/11 0 1 1000	, ,	1-1-0-010				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 3, MAY 1999 10:04 PM FRANCES ETTER /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Charles LaPlata Genesis Elder Care If Under 1 Yeer | If Under 24 Hrs. 9. Birthplece (State or Foreign County) Mary land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F Vrs 1912 87 577-18-4598 Mar. 6, Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Charles LaPlata Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Magnolia Drive 20646 U. S. A. Funeral 14. Race - American Indian, Bleck, While, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by 3 N Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Electric Contractor Owner/Operator 11 other 7 is marked other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Department of Health and Mental hy Ringortanth if them 27 is marked oth any Injury of other traumatic event place. Be Ellen McDermott William Hall 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Neme/Relationship (Type, Print) 276 Bradley Drive, Valentines, Virginia 23887 Joanne E. Weingarden/Daughter Baitimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Burin 2 Cremetion 3 Removel from State Trinity Memorial Gardens 05-07-1999 Waldorf, Maryland 4 Donation Other (Specify) 22. Name and Address of Facility
The Huntt Funeral Home, Inc. of al Sort Confice 21. Signature of Fe MARK G. BROHAWN M00053 P.O. Box 156, Waldorf, Maryland 20604 mew 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shoot, or heart failure. List only one gause on each line. Approximete Interval Between Onsel end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial Box 68760 death certificate be. Physician/Medical Due to (or as e consequence of): attending pl Pert ff. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 4 signed by t d be detact 1 Yes 2 No 3 Probably Wnknown Records, by 24b. Wera autopsy findings eveileble prior to Completed 24e. Wes en autopsy performed? 9 completion of cause of death? line. page 2 2 å 1 🗆 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 ☐ Yes # funeral 28e. Dete of Injury (Month, Dey Year) Certification: 27. Margner of Deett 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? if or Attending P after death. Director: After 1 Zelatural 2 Accident 5 Pending 1 Yes 2 No investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

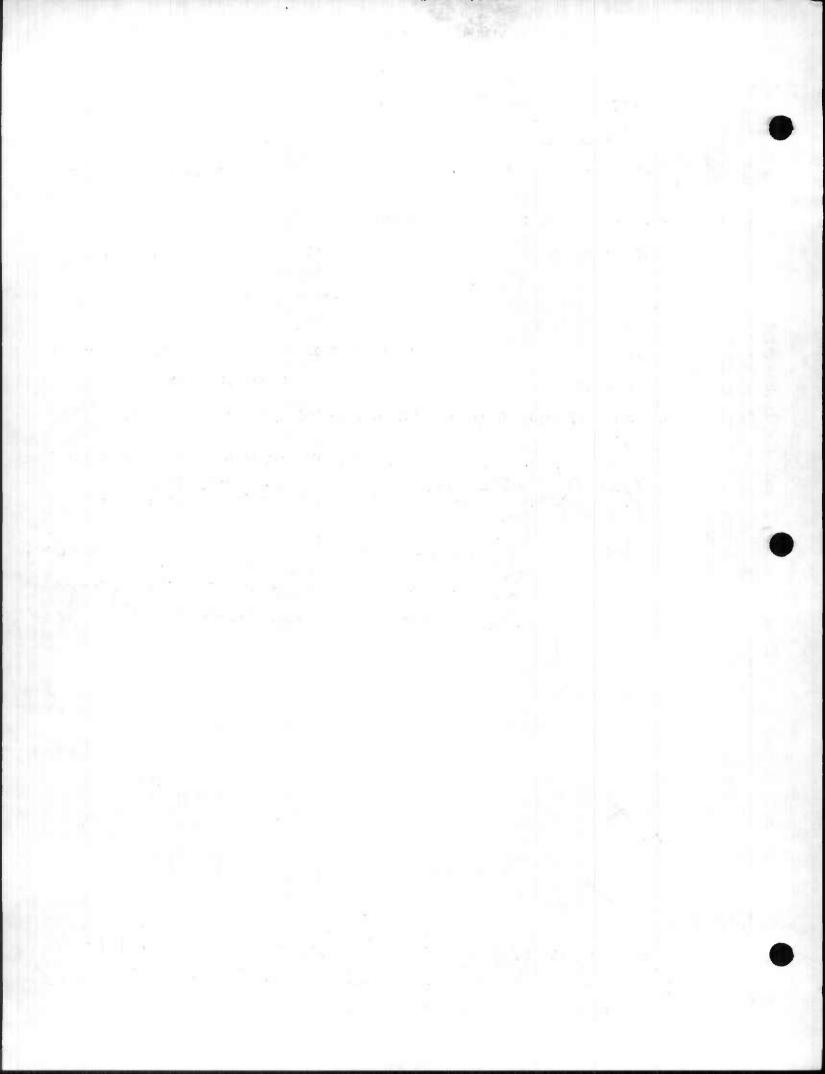
Local Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. edical 29a. Certifier To the Within 2 To the 29b. Signature and title of certified ALDORF, MU

State Registrar 31. Dete filed (Month, Day, Year

MAY

07 1999

32. Registrar's Signeture

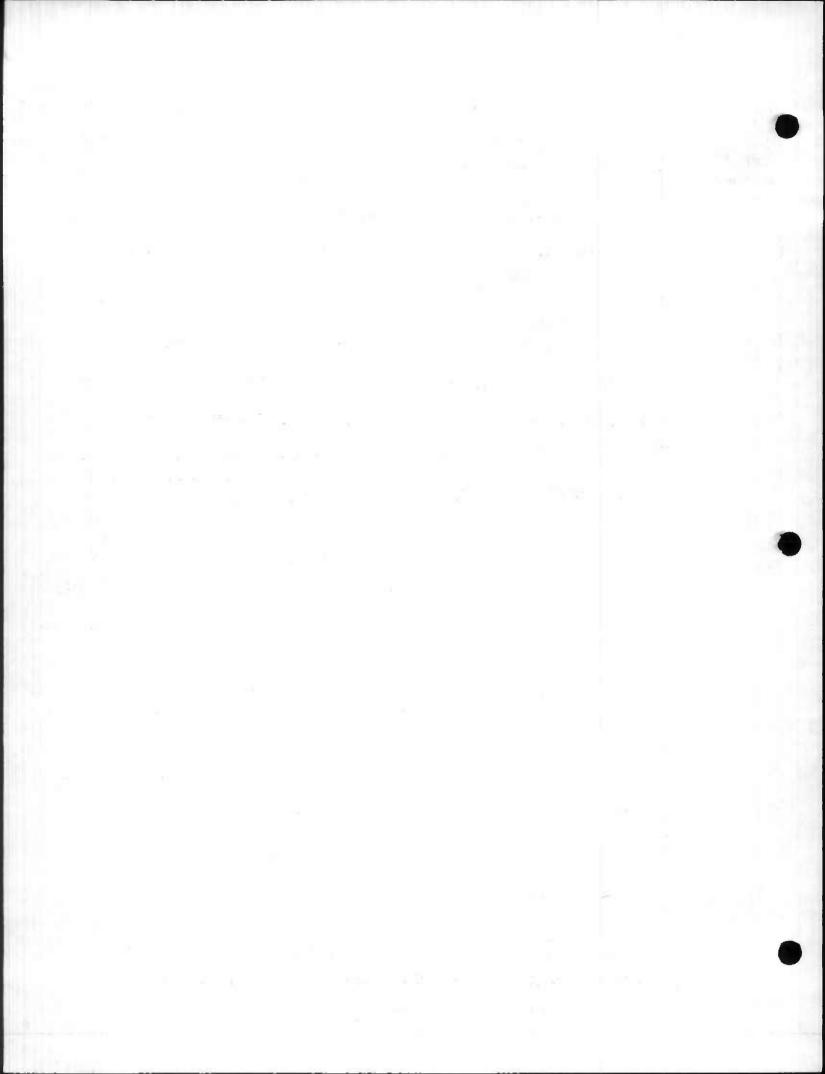


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant'e Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month ELLIOTT MARIE LILLIE 5:05 pm 1999 06 May /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cambridge Dorchester Mallard Bay Center If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 250 F 79 212-12-3511 Yrs Director 1 - 30 - 20Maryland Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at Tesyes 2□ No Director Dorchester Cambridge MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? itams 23a or 21613 U.S.A. 302 Cedar St. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 200 No
If Yes, Give
Yeer or Dates: Wes Decedenf of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 □ Yes 2/ No 'natural', or Specify: white by 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be find within 72 hou. Department of Health and Mental Hygiene. Important: If Item 27 is marked other tran "natural" any injury or other traumatic event. Completed 16e. Decedent's Usuel Occupetion
(Give kind of work dona during most of working
life. DO NOT use ratired)
Crab picker 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) seafood 11 17. Father's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) Be Hansel Travers Nola Travers 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Cambridge MD 21613 Leonard F. Elliott - son 3 Buena Vista Ave. 20e. Method of Disposition 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 12 Suriel 2 Cremetion 3 Removal from State Dorchester Memorial Park 5-8-99 □ Donetion 5 □ Other (Specify) Cambridge Maryland 22. Name end Address of Fecility 21. Signeture of Euneral Service Licenses Thomas Funeral Home PA etter 700 Locust St. Cambridge MD 21613 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediete Ceusa (Final diseese or condition rasulting in daath) /Medical Medestake Examiner Physician/Medical Examiner physician end s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Enter Undarlying Ceuse (Disaasa or Injury that Initieted avants resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Joenl Due to (or es e consequence of): 80 for use es deteched Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 2000 3 Probably 4 Unknown Completed by 24e. Wes en eutopsy 24b. Ware eutopsy findings performed' completion of cause of death? has page 2 2000 this certificate 1 Yes 1 ☐ Yes - ₽ ☐ No or Attending Physician: director Be 25. Was cese referred to medical exeminer? 26. Plece of Death (Check only ona) Hospital: Other: 4 TrursIng Homa 5 Residence 6 Other (Specify) 1 Yes 20€No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth Certification: 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred After **DENatural** 5 Panding invastigation To the Hospital or Attendir within 24 hours efter deeth.

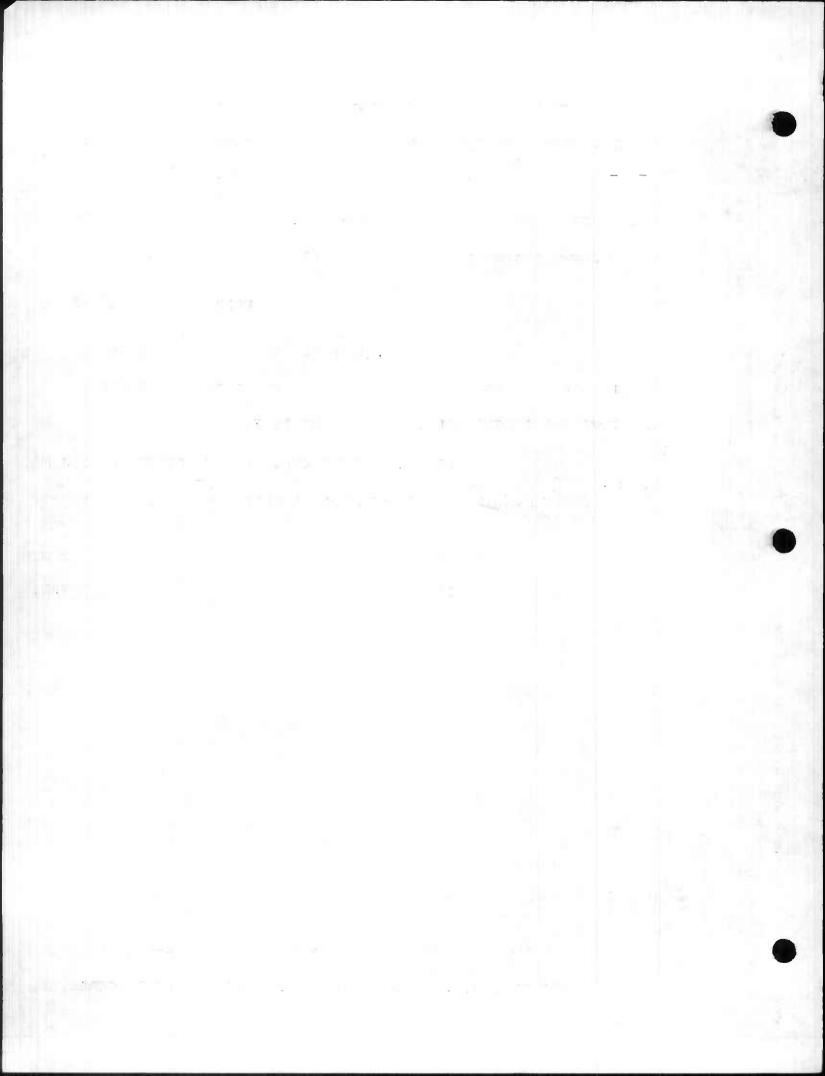
To the Funeral Director: All completely filled in by the fu deeth. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 - Homicida 29a. Cartifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, dete end place, and dua to the ceuse(s) end menner statad. Medical (Check only one) 29b. Signetyround fittle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who complated ceusa of daath (Itam 23e) (Type, Print) 300 AURORA STREET CAMBRIDGE, MD 21613 DR VINODRAI MEHTA 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAY 0 7 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

				Certificat	te of	Death		Reg. No.	1	0.960
Physician	Decedent's Name (First, Middle, I	.ast)					2. Date of De Month	Day	Year	3. Time of Death
/Medical Examiner	FELIC 4s Facility Name (# not institution, g			NANDIN:		4b. City, Town, or	MAY Location of Deatl		999 of Death	9:22 AM
	MANOR CA	RE NURST	NG HOM	ie.		CHEVY	CHASE	MC	NTGC	MERY
neral		Sex 7. A	ge (In yrs. last bi	irthday) If Unde	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		lace (State or Foreign
ctor	212-78-3086 Usual Residence of Decedent	1UM 201F	91	Yrs.	Days	Tiodis Will.	NOV. 2	23,1907	PE	ERU
frector	10s. State 10b. County		10c. City, Tov	vn or Location					1	0d. Inside City Limits
Director	MD. MONTGO	OMERY		CHE	VY C	CHASE				1 Ves 2 No
Sire.	10e. Street and Number			10f. Zip	Code			10g. Citizen of \	What Coun	itry?
	3805 JONES	BRIDGE	RD.		20	815		U.	S.A.	
Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Dece	dent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		e - Americ	an Indian,
by Fu	1 Never Married 2 Married	1 ☐ Yes 2XI	No	XX Yes		Specify:		Specify	,	
	3 NWidowed 4 □ Divorced	Year or Detes:	140			PEI	RUVIAN	401-1/1-1-4-1		SPANIC
lete	15. Decedent's (Specify only highest of	rade completed)	168	 Decedent's Usu (Give kind of wo life. DO NOT u 	ork done	during most of wor	king	16b. Kind of B	usiness/inc	dustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	HOM				12	OME	
	17. Father's Name (First, Middle, La.		1	110111	T.IVII.	18. Mother's Nar	ne (First, Middle			
o Be	EULOGIO	CAF	20			7771	RGINIA	CA	RRAS	SCO.
Ĕ	19a. Informant's Name/Relationship			h Mailing Address	s (Street	and Number or Ru				
	CONSTANZA F						ITEM #1		0.0.0, 24	
	20a. Method of Disposition	SIMANDINI	20b. Place	of Disposition (Na	me of		Date	20c. Location -	City or To	wn, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec			ery, crematory or o		1	- /5 /00	OTTIV	D 01	DING NO
	21. Signature of Funeral Service Lip	***	GATE		****	ss of Facility	5/5/99			PRING, MD.
	1/2/1/h	mlessa	2м0009			FUNER		ERDALE		20737
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death. Do							Approximate Interval Between
	arrow, or rival randro. Est or	y checuado chi duchi i	nio.						1	Onsel and Death
	Immediate Cause (Final disease or condition	CACE	HEXIA						- 1	1 MONTH
	resulting in death)	a. Crici.	The second second	consequence of)	:					1 HOWIT
ner		DEME	ENTIA							3 YRS.
Examiner	Sequentially list conditions,	ь		consequence of):	:					3 110.
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								i	
edical	that initiated events resulting in death) Last	C	Due to (or as a	consequence of):					1	
		d								
Physician/M	Part II. Other significant conditions	contribution to double	out not reculting	in the underbring	201100 001	on in Part I	22b Dld	tohnooo use oo	ndelhuda te	the cause of death?
hys	I Bit II. Odiai algimoatit conditiona	Contributing to obatif t	out not resulting	in the diluenying t	Jause giv	on erraiti.		Yes 2 No		bebly 4 Unknown
by P								200110	0_110	out, and the second
B							24a. Was	an autopsy		ere autopsy lindings allable prior to
Completed							pone	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CO	mpletion of cause death?
E							10	Yes 2 No	10	Yes 2□ No
	25. Was case referred to medical			····		26. Place of Dec	ath (Check only	one)		
To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/O	utpalient 3 D	OA Oth	77 77	lome 5 ☐ Resi		er (Specif	(v)
	27. Magner of Death	28a. Date of Inju	ury 28b.		28c. Injur Wor			how injury occur		
읥	1 Natural 5 Pending 2 Accident investigati		y rour)	fnjury M		Yes 2 □ No				
Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of in	jury - At home, fac. (Specify)	arm, street, factor	y, office		28f. Location (City or To	Street and Numb	per or Rure	I Route Number,
Ce								,,		
edical	29a. Certifier 12 Certifying F (Check only one)	hysician: To the best aminer: On the basis of and manner st	of examination as	e, death occurred nd/or investigation	at the tir , in my o	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and middle and place,	and due to	tated. the cause(s)
2	29b. Signature and title of certifier	ano mariner si	ateu.	29	c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	> Ellen f	inhout	MD			-1015				
				(Toma Paint)	D:	51015		MAY	4,	1999
	30. Name and address of person wh				CORTO	TAT ATT	#1041	OTTOT	737 07	IACE ME
tate	ELLEN P 31. Date filed (Month, Day, Year)	INHOLT, N	rar's Signature				· , #IU45	, CHEV	Y CF	HASE, MD.
State		99 Arms	we	G. Spo						



n	1. Decedent's Name						Death	2. Date of D		3. Time o
al .		Inez	Banta	Ganey				Month May	3, 1999	
er e	4a Facility Name (#			umber)				or Location of Deal		
	Holy Cr 5. Social Security No.		spital 6. Sex	7. Age (In yrs.	fant hidhelaul	If Under 1 Yes	Silver S	2		omery
	578-24-98	808	1□ M 2 S F	8		Months Day		in. (Month, D. Aug.]	8, 1910	9. Birthplaca (State Country) New Mexico
ŀ	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Loc	ation				10d. Inside C
	Md	P.G			Hyatts	sville				1 ⊠ Yes
1	10e. Street and Num				11, 0.00.	10f. Zip Code			10g. Citizen of W	fhat Country?
	5009 37	7th. Ave	3.			20	782		U.S.A.	
	11. Marital Status 1 Never Marrie 3 Widowed		Armed	2 No Sive	и	/as Decedent or Yes, specify Cu ☐ Yes 210 N	ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		e - American Indian, k, White, etc.
		15. Decedent's		Duitos.	16a. Decede	ent's Usual Occ	upation		16b. Kind of Bu	
		ify only highest	grade completed	(1-4or 5+)	(Give k life. D	cind of work dor O NOT use reti Countan	e during most of (ed)	vorking		nd Gov't.
	17. Father's Name (Abrahm		Banta				18. Mother's I	lame (First, Middle T)	, Maiden Sumame rujellio	θ)
	19a. Informant's Na	me/Relationshi	ip (Type, Print)		19b. Meiling	Address (Stre	et and Number or	Rural Route Numi	ber, City or Town,	Stete, Zip Code)
	Bonnie K	Kessler	(Daught			Hollywo	od Ave.	7		Md. 20904
	20a. Method of Disp		3 ☐Removel from		lace of Dispos emetery, crem	sition (Name of etory or other p	lece)	Date	20c. Location -	City or Town, Stete
	4 Donation	5 Other (Spe	scify)			ln Ceme		5/6/99	Brentwo	
	21. Signature of Fur	neral Service Li	censee / #	670 /	22.	Name and Add	ress of Facility C	hambers I	Funeral H	Homes, P.A.
	23a. Part1. Enter th	25	In	amlen				e. River		20737
Examiner	Sequentially list con if any, leading to imcause. Enter Under	nditions,	b. Acu	Due to (c	er as a consequence of as a consequence of a consequence	uence of): Uall uence of):	nyocaro	lial IN	faretism	
dical E	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	injury	c	Due to (o	r as a consequ	ience of):				1
M										1
	Part II. Other signific	cant condition	e contributing to	death but not res	ulting In the un	derlying cause	given in Pert I.	23b. Die	I tobacco use con	ntribute to the cause
Dy Fligelcial Vm				death but not res	ulting In the un	derlying cause	given in Pert I.	2.11111		ntribute to the cause
war for the monde		rtensic Fibri		death but not res	ulting In the un	derlying cause	given in Pert I.	1 [24a, Wa		
and the second s				death but not res	ulting In the un	derlying cause	given in Pert I.	1E 24a. Wa	Yes 2 No	3 Probably 4 2 24b. Were autopsy available prior completion of
Se completed by Physician/Mi	Atriac 25. Was case reform examiner?	rtensic Fibri	lation !		ulting In the un		26. Place of	24a. Wa per	Yes 2 No s an autopsy ormed? Yes 2 No one)	3 Probably 42 24b. Were autopsy available prior completion of of death? 1 Yes 2
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Celulication: 10 De	A fara C 25. Was case referrexaminer? 1 yes 2 12 1 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	red to medical No 1	Hospital: Ation ation ation ation Physician: To the particular of	e of Injury onth, Day Year) be of Injury - At hiding, etc. (Specifies best of my knobasis of examina	ER/Outpatient 28b. Time of Injury ome, ferm, stre y)	28c. In V 1 28c, In V 1 28c, In Cocurred at the	26. Place of I Other: 4 Nursin jury at ork? Yes 2 No e	24a. Wa peri	Yes 2 No s an autopsy formed? Yes 2 No one) sidence 6 Othe how injury occurr (Street and Numbown, State)	3 Probably 4 2 24b. Were autopsy available prior completion of of death? 1 Yes 2 er (Specify) red
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death May 3, 1999 Year **Physician** 5:30 AM I1ah Elizabeth Gieser /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rethesda Suburban Hospital If Under 24 Hrs. If Under 1 Ye 8. Date of Birth (Month, Dey, Year) Dec. 14, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Months Days Hours 1□M 2□F Michigan 88 Yrs Director 578-09-7247 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Garrett Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 11106 Kenilworth Avenue 20896 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White p 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Elementary School Teacher 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Elizabeth Griswold To Willard Case 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informent's Neme/Relationship (Type, Print) 8350 Broad Neck Road, Chestertown, Maryland 21620 Stephen Willard Gieser (son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 5-4-99 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Rapp Funeral Services, P.A. Lec 933 Gist Avenue, Silver Spring, Maryland 20910 NO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart falture. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) Respiratory Failure Due to (or as a consequence of): Examiner Stoke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease Physician/Medical Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Sick Sinus Syndrome, Seizures, 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24a. Was en autopsy Hypertension, Hepatic Dysfunction 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how Injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signeture 29c. License number 29d. Date signed (Month, Dey, Year) D26571 May 3, 1999 who completed cause of death (Item 23a) (Type, Print) 4930 Del Ray Avenue, Bethesda, Maryland Irving Mizus, M.D.,

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To the

Nerva 23a or 28a-f short Der must be nottfied at

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Department of Haalth and Mental Hy
Important: If them 27 is marked oth
any injury or other traumatic event

/Medical

Examiner

physician is the burial

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signed t

page 2

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,

within 24 hours a To the Funeral D completely filled

certificate be executed

requires that the death P.O.

The law

68760

Box

Records.

of Vital

Division

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

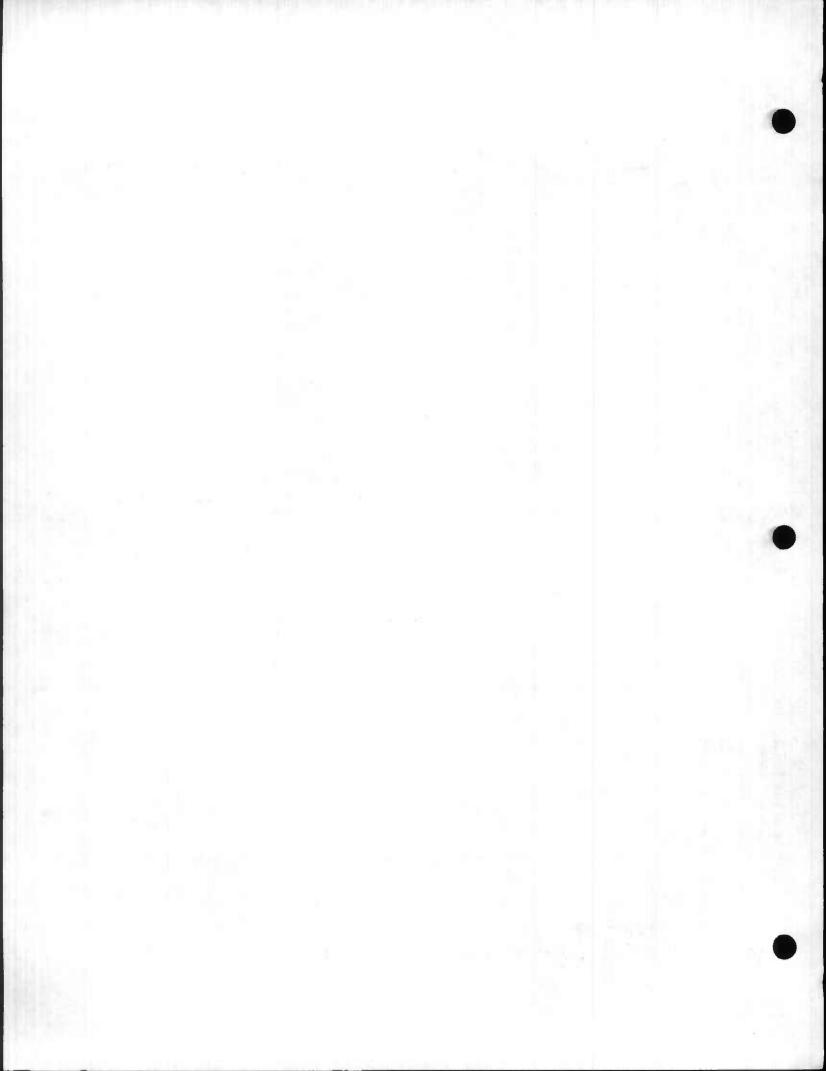
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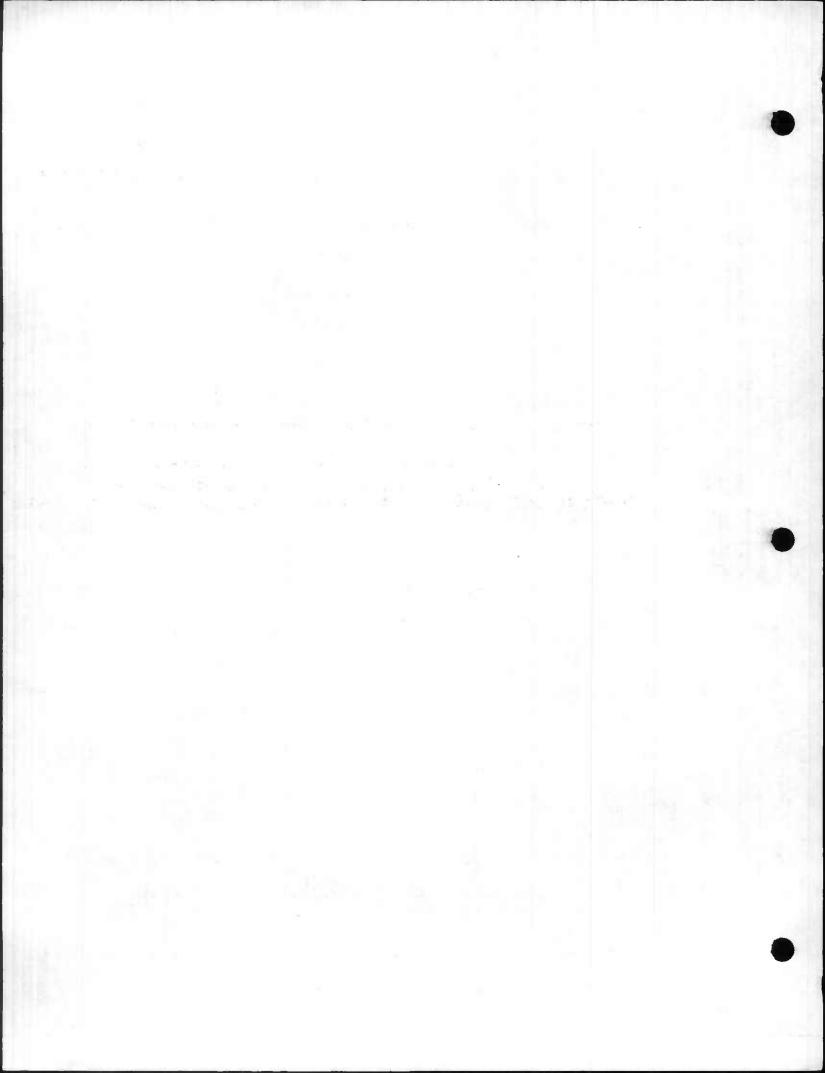
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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'n	3 🖾 Widowed		1 ☐ Yes 2 ☐ If Yes, Give 2 Year or Dates			1 🗆 Yes	2 ₩ No	Specify:		Specify:		+-	
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	19e. Intorment's Ne	me/Relationship (7	Type, Print)		19b. Meili	ing Addre	ss (Street	and Number or I	Rural Route Numb	er, City or Town	, Stete, Zip	Code)	
	Robert O.	Gordon		(son)	5327	Go1	sbor	o Road	Betheso	la,Maryl	land	20817	
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atic	1 StNatural 2 ☐ Accident	5 Pending investigation		ay ,	Year) Injury			Yes 2 □ No					
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	1	Tout	M	Xan	all) 1	079	32		May 1,	1999		
	30. Neme and addre	ss of person who	completed cause of	death (Item	23a) (Type.		. 019	J.L.		nay 1,	1777		
	Robert O.				rving		A AT	T.T T.T.	ah inata-	D C	20010		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month een WALTEN IMMY 1999 4pril 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) WESTMINSTER 2004 WALSH DRIVE ARROLL 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) 12M 20F Months Deys Hours Min 69 Yrs. 313-28-0439 Oct 13, 1929 OKINhomA Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10d. Inside City Limits ARROLL 1 Yes 2 No WESTMINSTER 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? DRIVE 200 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No 1951-13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 Yes 2000 If Yes, Give Yeer or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Supervisor 0 12 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Green LILLIAN DAVIDSON CUMAN 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, 2004 WALSH DEIVE WESTMINST 19a. Informapi's Name/Relationship/(Type, Oute Number, City or Town, State, Zip Code WESTMINSTEE, MD 6015 WIFE 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 KRemoval from State ent de Paul Cem. 5/3/99 Hanover, PA 22. Name and Address of Fecility POI HS FUNERAL HOME & Chapel 412 WAS HINGTON ROAD WESTMINSTER, MARY LAND 21157 It enter the mode of dying, such es cardiec or respiratory arrest, Approximate Interval Between Vincent de Paul 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the deeth. Do not e show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Ceuse (Finel disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 2 No 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner lew requires that the death certificate be executed and physician Division of Vital Records, P.O. Box 68760 attending the signed by to hes The certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital the 0

Completed by Be 2 Certification: edical

Examine Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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by

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7 is marked other than "natural", or ferms 23a or 28a-f shor traumatic avent, the Medical Examiner must be notified at

permit, Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, "the hypertant: if item 27 is marked other than "natural", or items 23a and Injury or other traumatic avent, tra

Physician /Medical

Baltimore, Maryland 21215-0020

the Maryland

State Registrar

nun

29c. License number 30

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

DINESH S. KALARIA 217

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·KALARIA

31. Date filed (Month, Day, Year) MAY 0 3 1999

29b. Signature and title of certifier

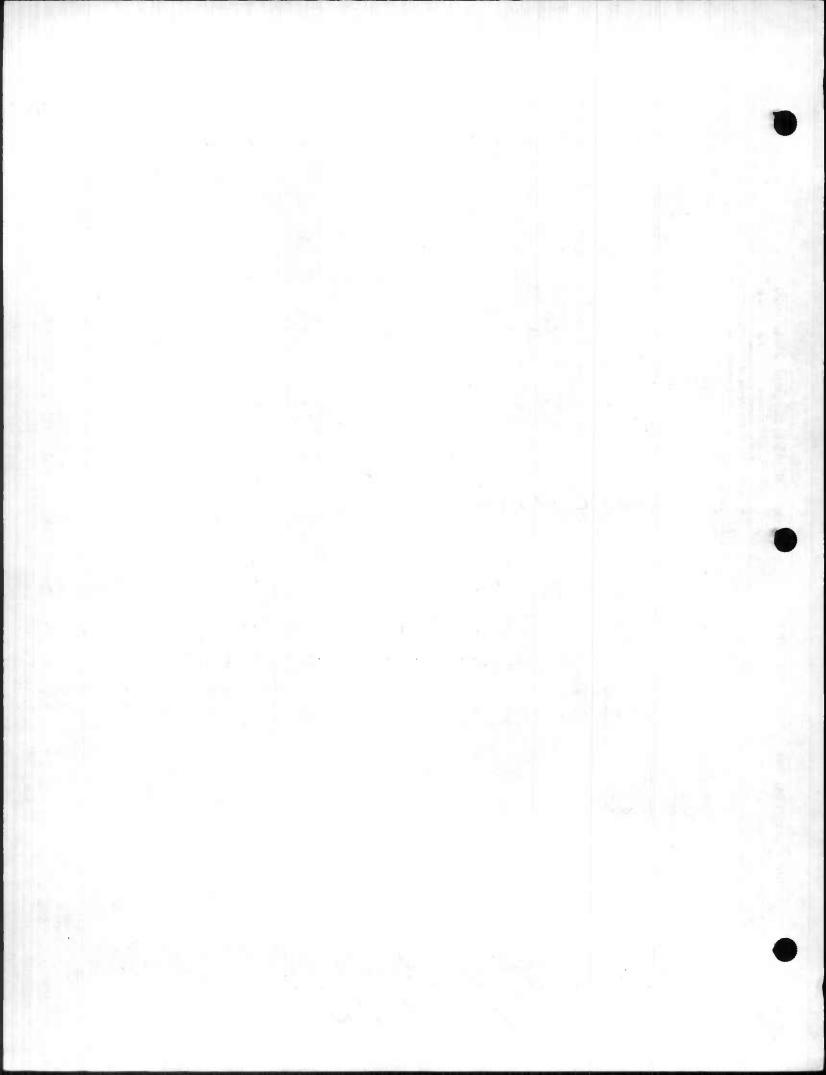
29a, Certifier (Check only one)

32. Registrer's Signeture

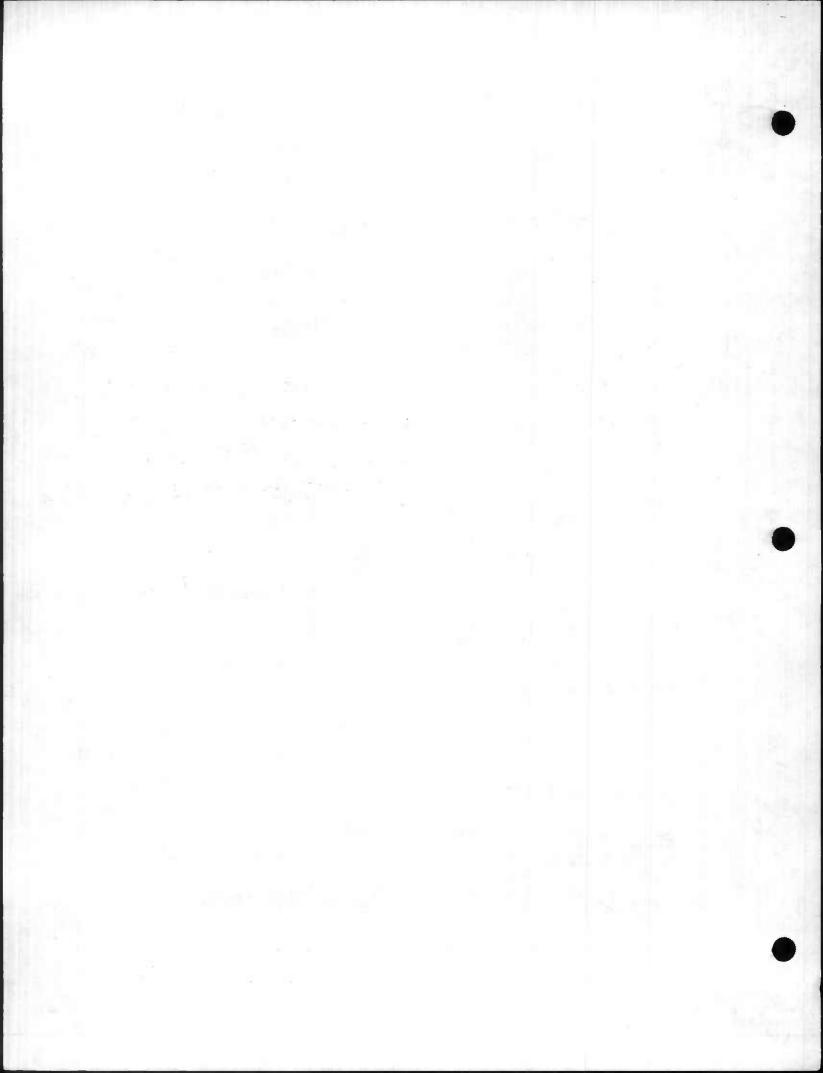
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State of Maryland / Department of Health and Mental Hygiene

				Certificate of	of Death		Reg. No.	15990	
1	nysician 'Medical xaminer	Decedent's Neme (First, Middle, Last) EMMETT FR Facility Neme (If not institution, give street end)	AVC 15	GOLDSB	OROUGH 4b. City, Town, or L	2. Dete of De	peth Dey	3. Time of Deeth 999 8. 17pr	
Fui	neral	JOHNS HOPKINS 5. Sociel Security Number 6. Sex	7. Age (In yrs. last I	birthday) If Under 1 Ye Months Da	ys Hours Min.	NECIT 8. Date of Bir (Month, De	th Year	N/A 9. Birthplace (State or Foreign Country) MARY LAND	
	ector	Usuel Residence of Decedent 10a. State 10b. County		own or Location		MAR. 3	, 1999 l	MARY LAND 10d. Ineide City Limits	
ith the Merylar	be notified Director	MARYLAND CARROLL COUNT 10e. Street end Number	Y	10f. Zip Cod	TANEYTOWN			1 ☑ Yes 2 ☐ No /hat Country?	
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21215-0020 d within 72 hours effer death with the Menyland gleine.		Elementery/Secondary (0-12) College	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)			king	16b. Kind of Bus		
be filed	B S	17. Father's Neme (First, Middle, Last) EMMETT RANDOLPH GOLDS			18. Mother's Neme (First, Middle, Maiden Sumeme) KAREN SUE SOWERS				
6 2 0	T T	19a. Informant's Neme/Relationship (Type, Print) EMMETT R. GCLDSBOROUG		9b. Mailing Address (Str. 102 EAST BAI				State, Zip Code) N, MD. 21787	
Peges	6	20a. Method of Disposition 1 A Buriel 2 Cremetion 3 Removel fro 4 Donetion 5 Other (Specify)	om Stete cemer	of Disposition (Name of tery, cremetory or other ST . MARY'S	plece)	Date MAY 1999		City or Town, Stete JRG, MARYLAND	
Baltim permit. Pe Departmen	eny in	21. Signeture of Funerel Service Licensee	v		dress of Facility SKI BALTIMORE			ME ROWN, MD. 21787	
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To the Hospital or within 24 hours after To the Funeral Direction	pletely fill	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and m	the best of my knowledge basis of examination enner steted.	end/or investigetion, in m	y opinion, death occur	and due to the red et the time,	cause(s) and mar date end place, e	nner as stated. and due to the ceuse(s)	
To T	woo M	296. Signatury and fittle of certifier Of Glywer Pi	CUFELL	0(V) 29c, Lice	ES-06	000	29d. Date signed MAX 2	(Month, Day, Year)	
		30. Name and address of person who completed of	GVERG	(Type, Print) 600 UERIAN	N. Wolfe	Street,	Baltimo S HOS	P/TAL.	
D.	State	31. Dete filed (Month, Dey, Year) 32	. Registrer's Signeture	4 10	./ ,				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** 1999 1009 e 4 5 mai 0623 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Cross 120 mort ves 10 mer If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplece (Stata or Foraign **Funeral** 1 MM 2□ F Yrs. JUNE 27, 1918 CYPRUS Director 80 213-58-9743 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. toside City Limits "natural", or literia 23a or 25a-f ahow 1 ☐ Yas 2 No Directo SILVER SPRING MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 UNITED STATES CANNON ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Meritel Stetus Black, Whita, atc filed within 72 hours after 1 Never Marriad 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BARBER OWN BUSNIESS 6 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of any injury or other treametic eve 2 COSTA HAJICOSTI KAY (UNOBTAINABLE) 19e. Intorment's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 711 CANNON ROAD SILVER SPRING, MD 20904 XENIA HAJICOSTI/DAUGHTER 20b. Place of Disposition (Nama of Dete MAY 05, 20a. Mathod of Disposition 20c. Location - City or Town, State cematary, cramatory or other place) 1 Burial 2 Cremation 3 Removal from Stata 1999 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN SILVER SPRING, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility HINES-RINALDI FUNERAL HOME, INC. Di My 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final Cerebrovascu diseesa or condition resulting in death) **Examiner** Due, to (or as a consequanca of): Examiner sician and burial-transit 0 Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medicai the Dua to (or as a consequence of) signed by the at d be detached for Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records. by 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? should page 2 2 X No 2 No certificate 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Wes case ratarred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2ER/Outpatient 3D DOA this 28e. Data of Injury (Month, Day Year) 27. Mannar ot Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding invastigation 1 Natural death. 1 Yes 2 No 2 Accident after death 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral D completely filled 29a. Cartifiar 📭 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data end place, end due to the cause(s) and mannar as stated. Medicat Examiner: On the bests of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannag-stated. (Check only To the 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) max 000428 LY M DME 2101 madical 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 120.1 SILVEY gpring BRECHER DME mn 31. Data filed (Month, Pay, Year) 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 55 999 MAY arover Kobert 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death oital Olney 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. Montgomery General Hospital Montgomery 6. Sex 1 D M 2 □ F 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Months Days Hours Min Yrs. 79 May 23, 1919 478-16-1239 Iowa Usual Rasidance of Dacedan 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20906 USA 15316 Pine Orchard Drive #2C 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Armed Forcas 1 Tay Yas 2 No If Yas, Giva Yaar or Datas: 1950— 1 Navar Marriad 2 Married 1 TYas 2 No. Specify Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Finance Officer Federal Government 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Gertrude Hockenberry G. T. Harover 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 11400 Norris Drive Silver Spring, Maryland 20902 Carol A. Howley (daughter) 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 5/13/99 4 Donation 5 Othar (Specify) Arlington National Cemetery Arlington, Virginia 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Fu eral Service License 500 University Blvd., W., Silver Spring, MD 20901 | 500 University Blvd., W., Silv | that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, so on each line. 23a. Part1. Enter the distance or complicate shock, or heart failure. List only one Approximata Intarval Betwaen Onset and Death Immadiata Causa (Final disaasa or condition rasulting in daath) ERY DISTAST ORONAR Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of):

Physician /Medical Examiner

certificate be execu

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

24 hours efter death.

To the Hosp within 24 hor To the Fune completely fi

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permit. Pages 1 end 2 sh Department of Health end Important: If Ifem 27 Is m any injury or other traum once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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7 is marked other than "natural", or ferms 23a or 28a-f show traumatic event, the Medical Examinat must be notified at

2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or ite

Baitimore, Maryland 21215-0020

physician and the burial-trans 88 USB o signed by the a pege 2 hes certificate director this After

funeral

Examiner Physician/Medical p Completed Be P. Certification: filled in by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy

24b. Wara autopsy findings available prior to completion of causa of daath?

1 Yas 2 No

1 □ Yas 2 □ No

25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No

2 Accidant 6 ☐ Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29d. Data signed (Month. Day, Year) 29c. Licansa number 29b. Signatura and titla of pentili

40365

30, Name and address of person was completed cause of death (Itam 23a) (Type, Print) 10313 Georgia Ave Suite 308 SASIA SILVER SPRING 20902

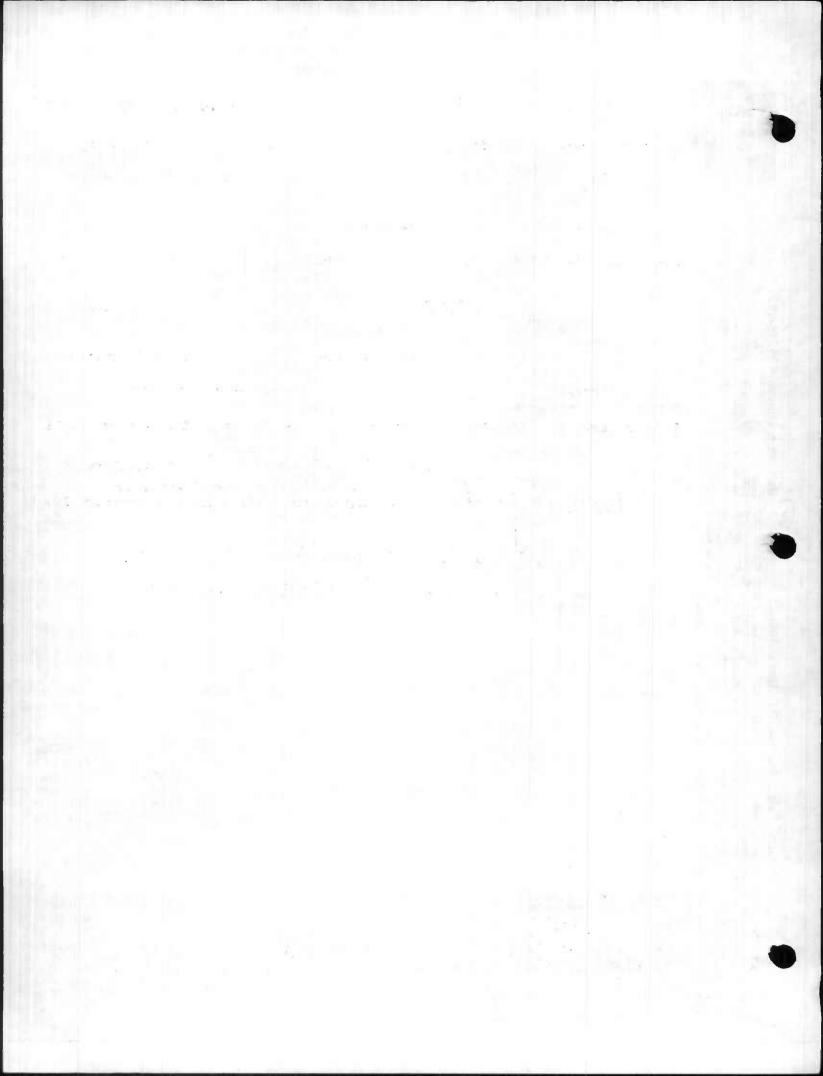
Registrar

Medical

31. Data filed (Month, Day, Year) **MAY 05** 1999

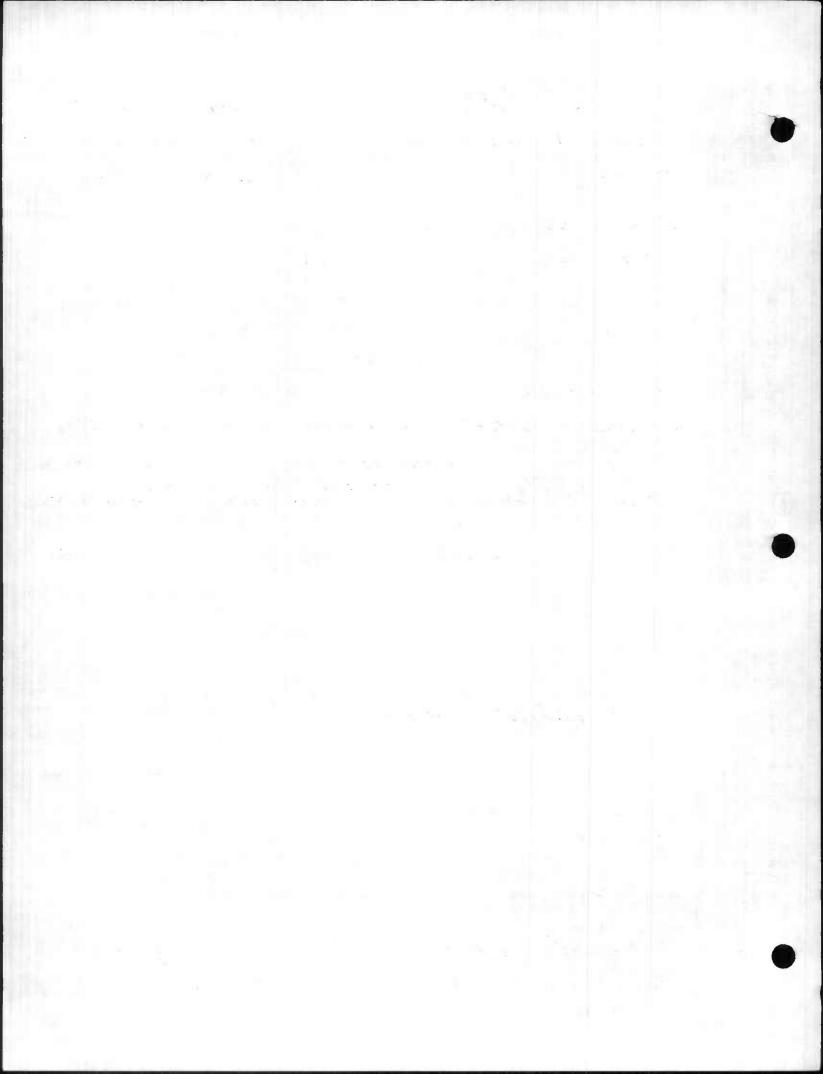
Deter

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3 Time of Death Month 745P **Physician** ARLENE MAY /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner Hospital Regional Prince George's Laurel aurei If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours Min 1□M 2♥F Director 220-46-7405 June 23, 1915 Idaho Usual Rasidanca of Dacadant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. insida City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☑ Yas 2 ☐ No Director Maryland | Prince George's Laurel 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda with 14107 Greenview Drive Funeral USA 14. Race - American Indian, Black, Whita, atc. 20708 death 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Hashib and Mental Hygiane. Important: If Item 27 is marked other than "naturel; or ite any injury or other traumatic event, the Medical Examina 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ 3 ₩idowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 Arthur Thomas Smith Otheldra Andrews 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Linda Bookhultz (daughter) 14107 Greenview Drive Laurel, Maryland 20708 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from State 4 Donation 3 Othar (Specify) 5/5/99 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licen-22. Nama and Addrass of Facility
Francis J. Collins Funeral Home, Inc. amse 500 University Blvd., W., Silver Spring, MD 20901 pur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting In death) Examiner Due to (or as a consequanca of): Examiner the death certificata be axecuted physician and the burial-transit Sequentially list conditions, if any, leading to Immedieta causa. Entar Undarlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Due to (or as a consequanca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Chematora authoriti 1 ☐ Yee 2 No 3 Probably 4 Unknown à 8 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 2 No 1 Yas 2 No Hospital or Attanding Physician:
 124 hours after death.
 Funeral Director: After this certifical. 25. Was casa referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 10 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Impatiant funeral 27. Manner of Death Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Panding Investigation 1 Yas 2 Accidant 3 Sulcida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 I Homicida 29a. Cartifiar 1 Certifying Physician: To tha best of my knowladga, death occurred at the time, date and place, and due to the ceuse(s) and mannar es stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) Indeen Kender AND 10 30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print) Cherry Lane, Laurel, Mit. 2020) Kundrat M.D. 8317 31. Data filed (Month, Dey, Year) MAY 0 5 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Huber Henry Heintzelman May 3, 1999 9:18 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Bethesda If Under 24 Hrs. 8 Hours Min. Suburban Hospital Montgomery 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 10 M 20 F Months Director 138-24-5344 76 April 21, 1923 Pennsylvania Usual Residence of Deceden the Maryland 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Hygiene. Hydiene than 'natural', or Nema 23a or 28a-f ahow ant, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6516 Lone Oak Court 20817 United States 12. Was Decedent Ever in U.S.
Amped Forces?

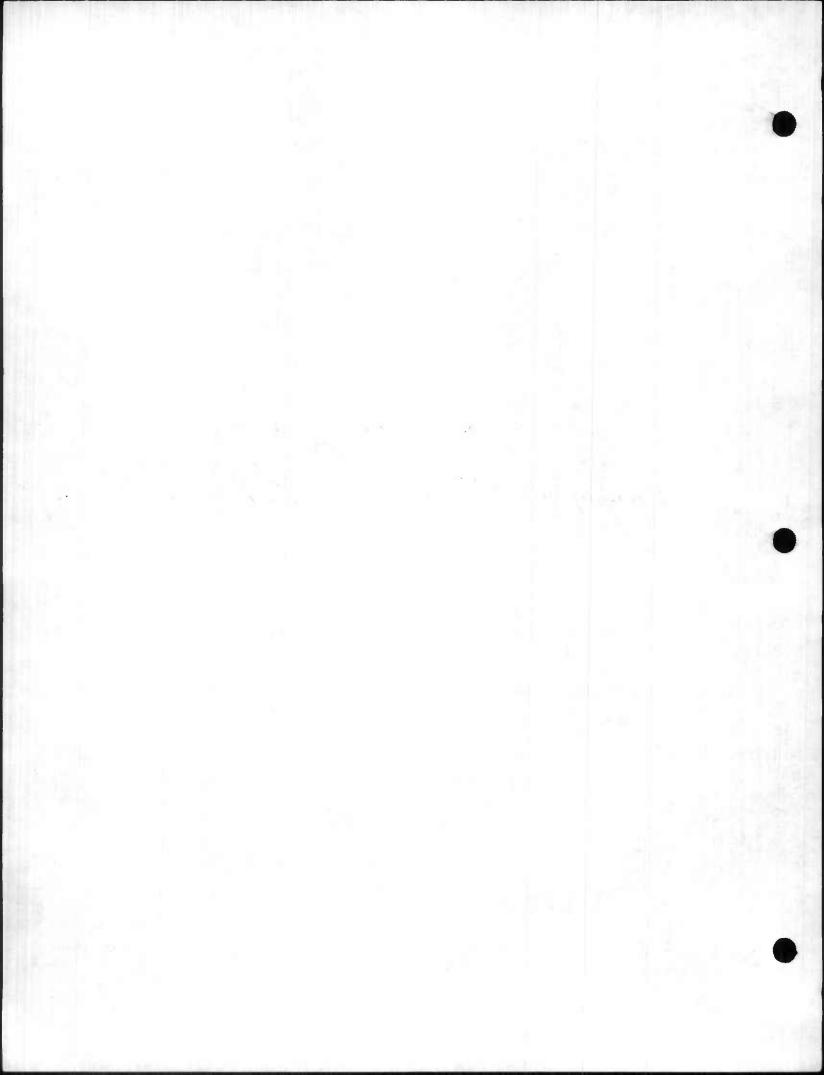
1 12 Yes 2 10 No
If Yes, Give World
Year or Dates: War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours ofter 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 5+ Analyst Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be I nent of Health and Mental I Stephen Huber Heintzelman Louise Henry 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stefe, Zip Code) or other tra Katherine Heintzelman /daughter 230 West End Avenue, Apt. 10E, New York, NY 10023 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Norland Cemetery May 7, 1999 Chambersburg, PA 21. Signature of Funerel Service Licensee M00831 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. annence (P) 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical metastatic lung 6 months cancer Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Due to (or as a consequence of): been signed by the atte should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? page 2 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mannes-of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 6 To the Hospital
within 24 hours a
To the Funeral I
completely filled Hospital 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) EN PREPS 25+1 May 04. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE A. SOTOS, MO 9707 medical Drive #300 pochville mo 20850 Center 31. Date filed (Month, Day, Year)
MAY 0 7 1999 32. Registrer's Signature State Dener Registrar

DHMH 16 Ray 6/95

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HENTLEMAN, HENRY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** ertz 1430 Herbert N. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hospita Atlantic General Berlin Morcester If Under 24 Hrs. 8. Date of Birth (Month, Day,) NOV 13, if Undar 1 Yaar 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthpiaca (State or Foreign **Funeral** Year) 930 Months Min. Days Hours 1₩ M 2□ F WASHINGTON DC 579-38-4324 68 Director Usual Residence of Decedent death with the Merylend 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits SUSSEX TV Yas 2 No DELAWARE MILLVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 219 CHAD PLACE 19970 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter Amed Polices?

I N Yes 2 □ No KOREAN

If Yes, Give

Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) REALTOR REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Peges 1 and 2 should be sent of Health and Mentel SAMUEL HERTZ RUTH KESSLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health em 27 is 219 CHAD PLACE - MILLVILLE, DELAWARE PEGGY HERTZ (WIFE) 20b. Place of Disposition (Name of cematery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NORBECK MEMORIAL PARK 4/30/99 OLNEY, MARYLAND 21. Signatura of Funarai Service Licensee 22. Name and Addrass of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Hottleme 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life death. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Lung CANCEK 8 months disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last end Due to (or es a consequence of): physician s the buriel Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched 1 XYes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 2 No 1 Ves 1 □ Yes 2 □ No certificate Division of Vital Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or n 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, deta end plece, and due to the cause(s) and menner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licensa number Physicia

State Registrar 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

1999

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32. Punistrar's Signature

31. Date filed (Month, Day, Year)

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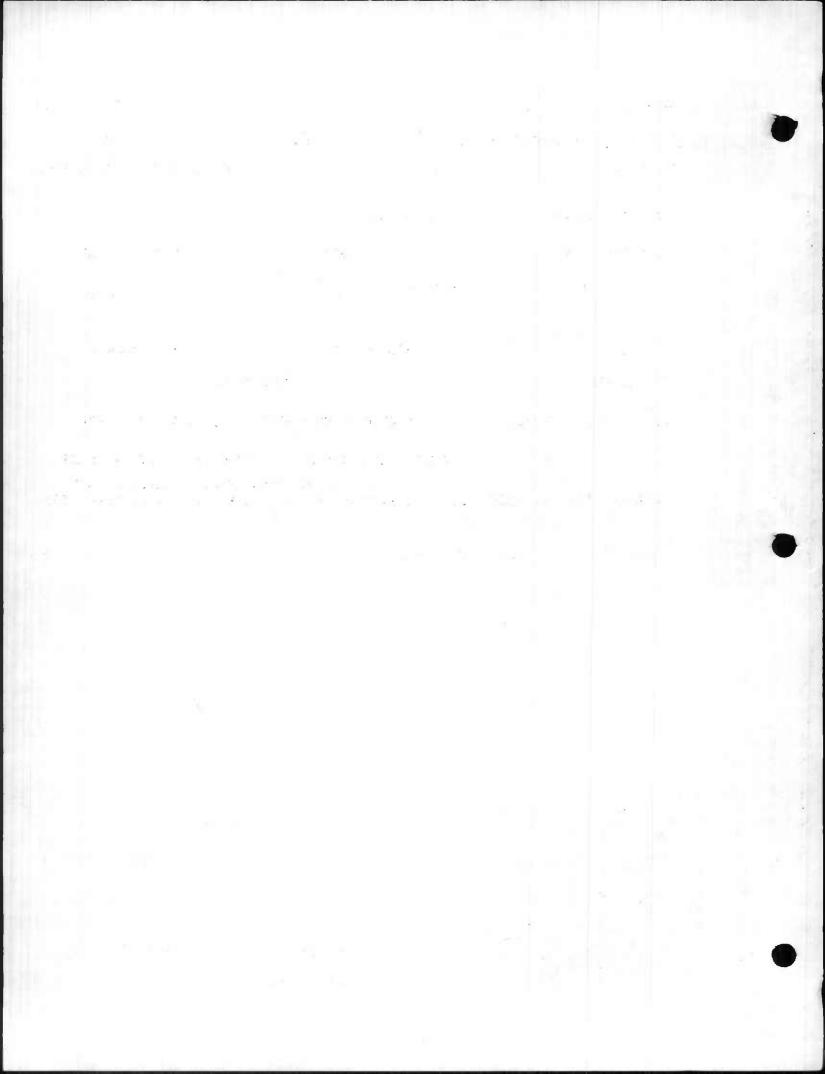
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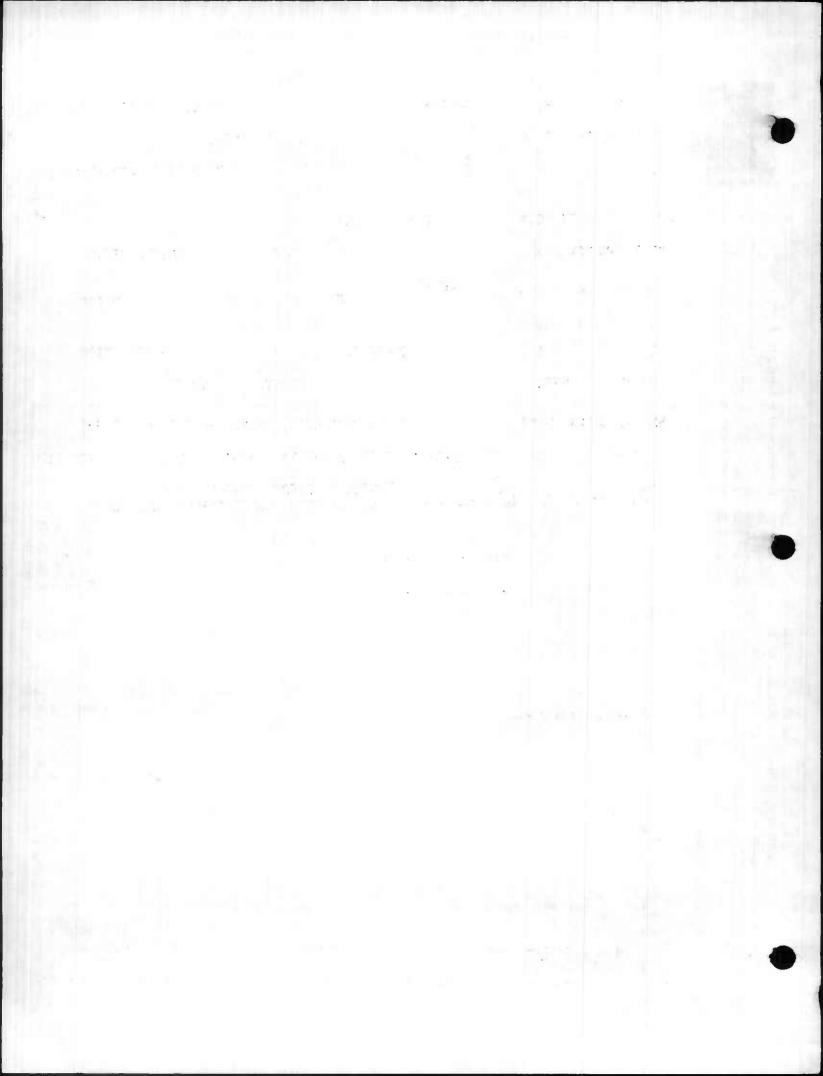
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HERTZ



State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificat	e or	Death			Reg. No.		
Physician										Year	3. Time of Death		
/Medical					rA			4b. City. To	wn. or Lo	MAY ocation of Deat	1	999 ty of Death	9:48 PM
Examiner	2121 NO						SILVER			SPRING MC		ONTGOMERY	
uneral Pirector	5. Sociel Security Number 193 12 65	34 1	3. Sex 7. Age (In yrs. 74		I last birthday) If Under 1 Year Months Days		Hours	er 24 Hrs. 8. Date of B		9. Bin 3, 1924 PEN		place (Stete or Foreigntry) SYLVANIA	
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to to	MD. MONTGOMERY SILVER SPRING									1 ☐ Yes 2 ☑ No			
be notified	10e. Street and Number 2121 NORBECK ROAD				10f. Zip Code					10g. Citizen of What Country?			
23a c					20906						UNITED STATES		
Andreid Wilder Hygiene. marked other than "natural", or items 23s or 28s-f show imstic event, the Medical Examiner must be notified at	11. Maritei Status 1 □ Never Merried 2 □ Merried 1 □ Never Merried 2 □ Merried 12. Was Decedent Ev. Armed Forces? 1 □ Never Merried 2 □ Merried 14. Was Decedent Ev. Armed Forces? 18. Was Decedent Ev. Armed Forces? 18. Was Decedent Ev. Armed Forces? 18. Was Decedent Ev. Armed Forces? 18. Was Decedent Ev. Armed Forces? 18. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces? 19. Was Decedent Ev. Armed Forces?			orces? 2 No WW						Sancifu:			
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4 5	19a. informant's Name										er, City or Tow		
m 27 ther tu	ANNA M. H		IFE	20h I	2121 Place of Dispo	NORB	ECK	ROAD,	SIL	VER SPI	RING, MI		
Important: If them 27 is any injury or other tra	20a. Method of Disposi 1 Burial 2 C 4 Donation 5	remation 3 [Carte	race of branch cemetery, cre rROPOL 1	metory or	other ple	ATORY	5	/3/99		DRIA, VIRGINIA	
Importa any Inju once.	21. Signeture of Funer	al Service Licer	name (1				ess of Fecili		IMEDAL	HOME		H H
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director.	25. Was cese referred examiner? 1 Yes 2 No	to medical	Hospitel:	inpatient 2	TER/Outpatio	ot 3□ D	OA Ot	e de		h (Check only		ther (Snec	iful
£ 65	27. Manner of Death	5 ☐ Pending	28a. Date (Mor		28b. Time of Injury Upday 28c. Injury at Work? 28d. Describe					e how injury occurred			
white A routs are beau. To the Funeral Director. After the completely filled in by the funeral Medical Certification:]	2 Accident 3 Suicide 4 Homicide	2 Accident Investigation 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fi						M 1 Yes 2 No et, factory, office 28f. Location City or			ation (Street end Number or Rural Route Number, or Town, State)		
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pletely fill edical	29a. Certifier 1 (Check only 2 one)	Certifying Ph Medical Exar	niner: On the t	e best of my kno basis of examina nner stated.	owledge, deet ation and/or in	h occurred vestigation	l et the ti	ime, dete er opinion, des	nd piace, ath occur	and due to the red at the time	cause(s) end i , date and piece	menner es	stated. to the ceuse(s)
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xl	3-4	1. m.	1	0			02:	3630			MAY 3,	1999	
	30. Neme end address			ise of death (ite	m 23a) (Type,	Print)	ICK	RO	#21	3. 6n.	THERS	BURG.	mo 20877
State	31. Date filed (Month, I			Begistrar's Sign									
Registrar	MAY	0 3 199	19 /	senera	Ø.	do	all.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Items 23b & 26, 5/3/99 State of Maryland / Department of Health and Mental Hygiene Per Phy., Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Earth Dey **Physician** Month William Kump Harbold

4e. Feclity Neme (If not institution, give street and number) 1999 APRIL 30 0210 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Apr. 9 19 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) **Funerai** 12 M 2□ F Deys 149-12-6908 Usuei Residence of Decedent Yrs Director 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Carroll 1 Yes 2 No Directo 10e. Street and Number 10g, Citizen of What Country? 234 Drive 74. S. A.

14. Race - American Indien,
Bleck, White, etc. 21158 by Funeral Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) traumatic event, the Modical Examiner filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0020 ò If Yes, Give Yeer or Dates: 1943. 1946 Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel", Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Senior Operation Officer Peges 1 end 2 should be filed in nent of Health end Mental Hygicant: If Item 27 is marked other Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Harbold aura Mercer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 s Department of Health er Important: if Item 27 is eny Injury or other trau 2344 Sykesville Rd., 20b. Plece of Disposition Nieme of cemetery, cremetory or other pleca) John Harbold, son Westminster, MD. 21157 20c. Location - City or Town, Stete 20e. Methad of Disposition Dete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Westminster, MD. 21. Signature of Funeral Seprice License 22. Name and Address of Facility Pritts Funcral Home & Chapel, P.A. 412 Washington Road 412 Washington Roa Westminster, MD. 23e. Pertif Enter the dease or complications that caused the death. Bo not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart forms. Left only one cause on each line. Approximete Intervei Between Onset end Deeth Physician immediete Ceuse (Final disease or condition resulting in deeth) /Medical e. MULTIPLE TRAUMA Examiner Due to (or es e consequence of): Physician/Medical Examiner ASCVD The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): the buriel-tran C2 FRACTURE Due to (or es e consequenca of): RETROPERITONEAL HEMATOMA Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? page 2 should Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. Injury et Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred After Division 5 Pending investigation injury 1 Neturel nours efter death. 1 Yes 2 No 2 Accident 4/29/99 1430 passenger mva 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 I Homicide To the Hospital c within 24 hours of To the Funeral Di RT 16 @ HICKMAN ROAD DENTON, MD 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the cause(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pieca, end due to the cause(s) end menner steted. Medicai 29a. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Yeer) 4/30/99 DWE 0.0. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SALISBUTY, MO christopher Snyder

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

and hopfar years in a consequence Source was National Assets Car III The rate of the state lease Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #1, Per Phy. 5/3/99, Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death HOUFF 2. Dete of Deeth DOROTHY Day **Physician** 1999 PRIC 30 16:00 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name //f not institution, give street end number) 4c. County of Death Examiner 40pKINS City HOSPITAL JOHNS 8. Dete of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** 1 M 2 F Months Days Hours Min. 218-10-9934 Usual Residence of Decedent Yrs. Director 10d. Inalde City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No MD.

10e. Street and Number Director Nestminster Carroll 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or itsumatic event, the Medical Examinar must be n P. O. 1536 21158 U.S.A Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 PNo Specify: Baltimore, Maryland 21215-0020 ğ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within Elementery/Secondery (0-12) College (1-4or 5+) Senior Citizen Manager Senior

18. Mother's Name First, Middle, Maiden Sumame) Senior Citizen is marked other 17. Father's Name (First, Middle, Last) Anna Minnie Klaschus Ira Nerim permit. Pages 1 and 2 should liberaries of Man Department of Health and Man Important. If them 27 is markes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Drive, Taney town 190 20c. Location - City or Town, State Cardyn Simmons, daugh Ter
20a. Method ot Disposition 20b. P Ter 87 Grand Dri
20b. Place of Disposition (Name of cametery, crematory or other place) 21787 1 Burial 2 Cremation 3 Removal from State 5-4-99 Hampstead 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 22. Name and Address of Facility PriTts Funeral Home Chapel, P.A.

#12 Washington Load

Westminster, MD. 2/157

Approximate only one cause on each line. 21. Signature of Fundal Service Licenses 23a. Part1. Enter the dishase, or conshock, or head feature. List only Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) 2 weeks Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): pue physician (thet the death certificate be Physician/Medical Due to (or as a consequence of): ed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t Unknown 1 Yes 2 No 3 Probably Failure Division of Vital Records, þ The law requires 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? Completed peen completion of ceuse of death? Seu 1 Yes 2000 1 Yes No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director. 25. Was cese referred to medical examiner?

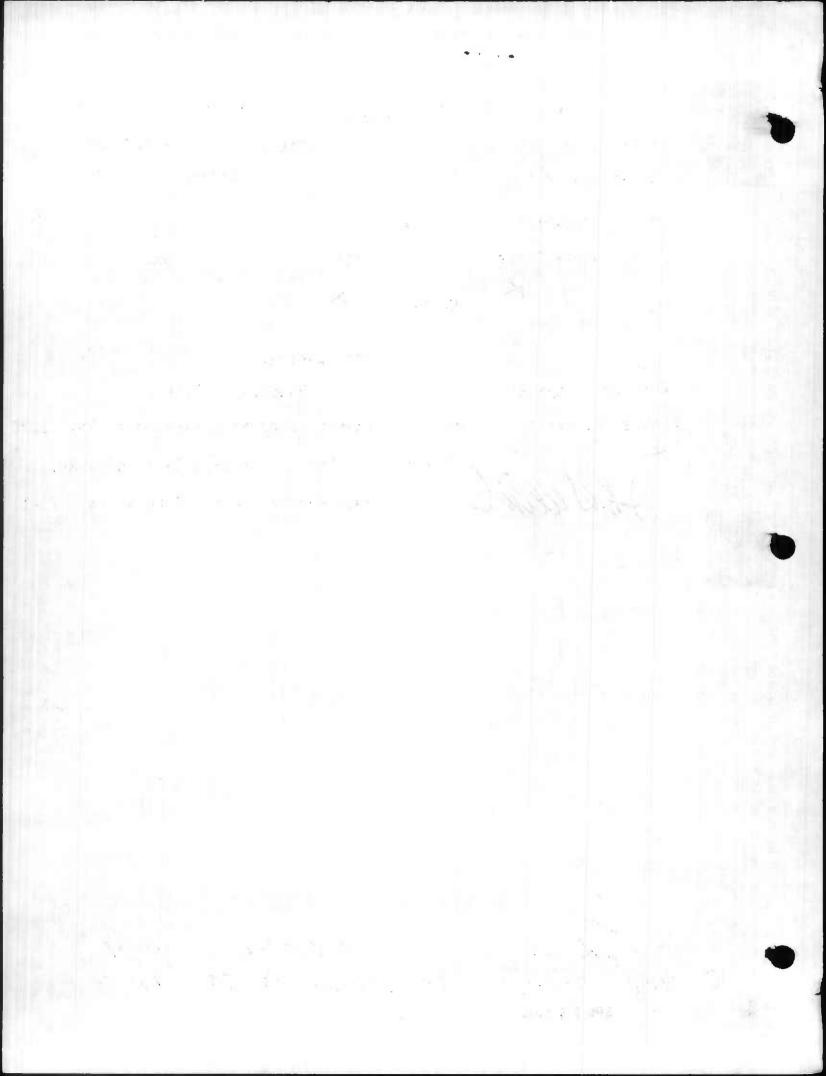
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mapner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, BALTIMORE, MID 21287 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Samdani Johns 600 North Male ST. 31. Date filed (Month, Day, Year) State Registrar

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Amended line 1 FCHD, KS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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sician end buriel-transit The lew requires that the death certificate be executed P.O. Box 68760. physician the Division of Vital Records. 8 page 2 should certificate or Attending Physician: funeral director, this Affer

1. Decedent's Name (First, Middle, Last) 2. Dele of Death 3. Time of Deeth Hilton Day Month May 1 1030 am Henrietta 101 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Health Care Center Frederick Frederick If Under 24 Hrs. 8. Dele of Birth Hours Min. 8. Dele of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yeer 9. Birthpiace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🖫 F Months Deys February Yrs. '25 Virginia 579-32-9910 74 Usual Residence of Decedent 10a Slete 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at MD Frederick Brunswick Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 124 7th Avenue 21716 USA items 23a Funeral 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, permit. Pages 1 and 2 should be filed within 72 hours efter of oppartment of Health and Mental Hygiene. Important: If tern 27 is marked other than "natural", or itel my jury or other traumatic event, me Medical East whe Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) John J. Studt Mary Henrietta Ankers 19e. informant's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Hilton, Son 124 7th Avenue, Brunswick, MD 21716 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Melhod of Disposition 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Union Cemetery 5/4/99 Lovettsville, VA 21. Signature of Funeral Service License Barbara A. John T. Williams Funeral Home Williams; Owner 100 Petersville Rd Brunswick MD 21716 Approximete Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. **Physician** Vessel Disease /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Completed by Physician/Medical Due to (or es e consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings 24a. Was an autopsy eveilable prior to completion of cause of death? 1 ☐ Yes 1 Tyes 2 No 25. Wes case referred to medical examiner? Be 28. Plece of Deeth (Check only one) examiner?
1 Yes 2N No
27. Manner of Death Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 24 hours after deeth. Funeral Director: A 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled In by 4 - Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and manner es steled.
2 Madical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) within 2 ů, 29b. Signeture end little of certifier 29c. License number 29d. Dale signed (Month, Dey, Year) 2 who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end address 60 31. Date filed (Month, Day 32. Registrar Signature State

Registrar

with processing and a